DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE AND SECURITIES REGULATION

Public Forum

Application of WellPoint Health Networks,Inc.
Regarding Conversion and Acquisition of Control of
Group Hospitalization and Medical Services, Inc.

Tuesday, May 28, 2002

6:00 p.m.

441 4th Street, N.W.
Auditorium
Washington, D.C. 20001

P R O C E E D I N G S

COMMISSIONER MIREL: Good evening, everybody. I am Larry Mirel, Commissioner of Insurance and Securities Regulation for the District of Columbia.

Tonight is the second of two scheduled public forums to hear from the public on the proposal by WellPoint Health Networks, Inc., a California-based health insurer, to purchase CareFirst, a Maryland-based health insurer. CareFirst is the parent corporation of Group Hospitalization and Medical Services, Inc., GHMSI, the District's Blue Cross/Blue Shield health plan. CareFirst also controls Blue Cross operations in Maryland and Delaware.

CareFirst is a non-profit corporation. WellPoint is a for-profit corporation. Part of the proposed transaction would require that CareFirst be converted to a for-profit entity so that WellPoint can purchase its stock. The value of CareFirst, as reflected in its sale of stock to WellPoint, would be put into trust for the benefit

of the people of the affected jurisdictions. WellPoint's proposed purchase price for CareFirst is $1.3 billion.

With me at the table tonight are Leslie Johnson, to my right, Hearing Officer for the Department of Insurance and Securities Regulation, who will assist me with the procedural aspects of this process; and Ark Monroe, an attorney with the Little Rock, Arkansas, law firm of Mitchell, Williams, Selig, Gates and Woodyard, which has substantial experience with the conversion and sale of Blue Cross entities. Mitchell Williams has been retained by DISR to provide legal advice on this complex proposed transaction.

Let be begin by describing the process we will follow. For the proposed transaction to go forward, it needs the approval of the insurance commissioners of the three affected jurisdictions: the District of Columbia, Maryland, and Delaware. Before I can approve the transaction on behalf of the District of Columbia, I must be assured by the D.C. Corporation Counsel that the District's share

of the proceeds of the sale is adequate, and that the funds are properly protected for the benefit of the public. The attorneys general of Maryland and Delaware have similar functions to perform under their state laws. Finally, because GHMSI--the District's Blue Cross/Blue Shield program--is chartered as a non-profit corporation by Congress, congressional approval is also needed.

Tonight we are continuing the first part of our review process, which is to hear from the public on this proposal. Although this is the last scheduled public forum, if there are persons who wish to be heard and were unable to appear last week or tonight, we will be willing to hold an additional public forum. I will not set a time and place for a third session unless and until I know there is a need.

We will also be hiring experts to analyze the documents WellPoint has put forward in support of the proposed transaction, including a financial expert. The Office of the Corporation Counsel will separately retain an investment banking firm to

value CareFirst and GHMSI and assist in the establishment of a charitable foundation if the transaction is approved.

Finally, a formal hearing will be held sometime in the fall of this year, at which WellPoint will present its proposal and opposing parties will have an opportunity to present evidence and witnesses in opposition as well as to cross-examine WellPoint's witnesses.

After reviewing the entire record, and receiving a decision from the Corporation Counsel as to the value of the transaction and protection of the assets for the public, I will render my decision whether to approve or disapprove the proposed transaction.

The standards governing the determination I must make as commissioner are set out in two District of Columbia statutes. The first deals with the issue of whether CareFirst/GHMSI should be allowed to convert from non-profit to for-profit. The law says that the conversion shall be approved unless I find that the plan:

One, is inequitable to contract holders of the converting corporation, or to the public;

Two, fails to comply with certain procedural requirements;

Three, provides that any part of the assets or surplus of the corporation will inure directly or indirectly to any of its officers, directors, or trustees; or

Four, does not ensure that WellPoint, as the resulting stock insurance company, will possess capital and surplus in an amount sufficient to comply with the capital and surplus requirements for a stock life insurance company under applicable law and to provide for the security of WellPoint's contract holders.

The second law is concerned with the standards for determining whether the acquisition of control of the District's Blue Cross/Blue Shield program--that's GHMSI--by WellPoint should be approved. The statute says that the transfer of control shall be approved unless, after a public hearing, I find that:

One, after change of control, the plan would not be able to satisfy the requirements for the issuance of a license to write accident and health insurance in D.C.;

Two, the effect of the acquisition of control would be to substantially lessen competition in insurance in D.C., or create a monopoly;

Three, the financial condition of WellPoint is such as might jeopardize the financial stability of GHMSI or prejudice the interest of its policy holders;

Four, WellPoint's plans or proposals, if any, to make material changes in the operations, structure, or management of GHMSI are unfair and unreasonable to policy holders of GHMSI and not in the public interest;

Five, the competence, experience, and integrity of management who would control the operations of GHMSI are such that it would not be in the interest of GHMSI's policy holders and of the public to permit the acquisition of control; or

Six, the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

At the formal hearing in the fall, there will be two ways to participate. If you simply have views that you wish to express, you will be afforded an opportunity to submit written comments. If you are interested in participating as a formal party, you must file a written motion to intervene which identifies the nature of your interest in the proceeding, states how the outcome of the proceeding will affect you, and describes any other factors that would warrant your participation as a party.

Any person who is allowed to participate as a party will be able to conduct discovery, offer evidence, examine witnesses, and file written briefs. Participation as a party will also carry with it significant responsibilities. Every person who participates as a party will be obliged to respond fully to discovery requests served by other parties. The witnesses offered by a party will

have to be made available for cross-examination by all other parties. Every party will be expected to attend all hearings and status conferences, to file briefs and pleadings, and to provide all other parties with formal service of all filings they make. The obligations are serious, and should not be undertaken lightly.

If you are interested in participating as a party, I encourage you to review the case management order--there are some of them over there on that table--to make sure you understand all of the relevant deadlines, opportunities, and obligations involved in participating in these proceedings.

The process of reviewing WellPoint's application is open to the public. All of the pleadings filed with the Department and all of the orders entered in this proceeding will be available for review at DISR. If you are online, all of the pleadings and orders are also available on the website that the Department has established for this matter. The address of the website is in my

written statement.

The WellPoint proposal was filed with our Department on January 11th, 2002. On April 5th, 2002, I issued a preliminary order--which is over on the side, again--finding that the application was deficient, in that it lacked sufficient detail to enable the Commissioner to make a thorough review and a reasoned decision. The applicants were directed to file a draft amended and restated application on or before July 16th, 2002, to remedy the deficiencies. A letter specifying what further information is needed was sent to WellPoint last week. Copies of that letter are also available on the table over on the side.

The reason we requested that the amended application be filed in draft form is that D.C. law requires that we render a decision within 30 days after a final application has been filed. We do not believe that 30 days will give the public, or our experts, enough time to properly evaluate the amended application. We have asked that the final application not be filed until October, so that the

clock for making a final decision will run from that date. If the final application filed in October differs significantly from the draft submitted in July, accommodations will be made to allow an opportunity for all parties to review the document and be adequately prepared for the hearing.

I want to thank all of you for coming here tonight. This is obviously an important decision for our community, and I want to proceed with full opportunity for the public to be heard.

The forum is scheduled for three hours, and we have more than 20 witnesses on the list. Therefore, I will ask that each witness limit his or her statement to not more than ten minutes. We will also accept written comments; so that if you did not sign up to testify in person or if your testimony has not been completed in the allotted time, please give us the benefit of your full comments in written form.

Although we have a full roster of witnesses, if we have completed the testimony

before nine o'clock, I will call upon any other persons waiting to speak. If anyone would like to be heard and was unable to participate in last week's forum or tonight's, please get in touch with Leslie Johnson about the possibility of scheduling an additional forum.

A full transcript of this hearing will be made so that I have a complete record before me when I make my decision. Therefore, when you are called upon to speak, please state your name, spell your last name and, if you are speaking on behalf of an organization, give the name of the organization.

We do have a witness here, I believe, tonight from CareFirst. And I will call upon her first. Ann Gallant.

And you are also limited by the ten-minute rule.

STATEMENT OF ANN GALLANT

VICE PRESIDENT, CORPORATE COMMUNICATIONS

CAREFIRST BLUE CROSS/BLUE SHIELD

MS. GALLANT: Thank you. Good evening.

I'm Ann Gallant. That's G-A-L-L-A-N-T. I'm vice president of corporate communications for CareFirst Blue Cross/Blue Shield. Thank you for the opportunity to speak tonight.

Our proposal: CareFirst is seeking to convert to for-profit and be acquired by WellPoint Health Networks, for $1.3 billion. This transaction needs approval by regulators in Maryland, Delaware, Washington, D.C., and in Congress.

This proposal has great potential to do good. WellPoint is paying 1.3 billion for CareFirst, money that could be used to address unmet health care needs in D.C., Maryland, and Delaware. This transaction is a "win-win-win."

The transaction positions us, CareFirst, so that we can ensure continuation of a stable, financially strong Blues Plan serving Maryland, Delaware, and the Washington region. We will continue to be Blue, since WellPoint is Blue. We will continue to be regulated as we are today, subject to the same requirements.

We will maintain current employment levels. Just as we saw with the affiliations of Maryland, D.C., and Delaware, so long as we are growing the company, employment should remain stable, or grow over time.

We will continue to be locally headquartered. Critics complain that decisions will be made three time zones away. In fact, WellPoint understands that the best health care is consumed and delivered locally. That is why it will maintain the existing headquarters at Owings Mills, in Washington, in Wilmington, and in fact establish a new southeast regional headquarters in this region.

We will maintain local management. Recognizing that it makes sense to have managers who understand the unique characteristics and needs of our customers here, WellPoint intends to maintain local management, as they have in Missouri and Georgia.

We will maintain reserve levels. Critics have suggested that WellPoint will use CareFirst

reserves to pay the bulk of this transaction. In fact, those reserves must remain in place to meet mandated levels by the regulators and of the Blue Cross/Blue Shield Association.

The transaction promises to make CareFirst even better. We plan to invest in upgraded IT systems; to answer calls more quickly and more accurately; 24-7 online capabilities; to allow doctors to file claims electronically, and have those claims adjudicated in real time; and to reduce hassles for members and for providers.

There will be more products and more options. WellPoint, for example, offers small employers a range of products; where, for example, "mom" could have a preferred provider plan, "dad" with a point-of-service plan, and the kids in a health maintenance organization.

Now, you may ask, "With all of these improvements, will my premiums increase?" The short answer is: No. That doesn't mean premiums won't increase. They will. But with added efficiencies, by spreading overhead costs over a

much broader base, the rate of increase should actually be slowed.

So CareFirst stays the same, keeping those features that our customers most value; and

CareFirst gets better, offering new products and services and slowing the rate of premium increases.

On just those two points alone, the value of the transaction should be apparent. But there is a third piece, with a tremendous opportunity to

do good, that makes the case. Because CareFirst's affiliate plans were founded as not-for-profits, which in the past received certain tax breaks and other benefits, the entire value of the combined companies must be returned to the community in the

form of charitable trusts.

Given WellPoint's purchase price for CareFirst, that means that $1.3 billion will be shared by Maryland, Delaware, and D.C. Our hope is that this money will go into foundations or

endowments where the principal will continue in perpetuity to fund health-related initiatives.

That means that, conservatively invested,

some $65 million will be available to elected officials in those three jurisdictions to spend on unmet health care needs. That, coupled with the approximately 24 million from CareFirst's payment of premium tax, equals nearly 90 million annually to address the needs of the uninsured and the under-insured.

CareFirst has been asked to offer our suggestions on how this money can be used. Some suggestions:

Establish a subsidized pharmacy program for senior citizens, similar to that established in Maryland;

Develop an open enrollment type health plan for those currently uninsurable due to preexisting conditions;

Offer community health clinics to the District's low-income residents.

These opportunities are endless.

In conclusion, our proposal ensures a strong Blues plan long term; preserves local employment; improves products and services; and

offers--there's a mistake here [referring to written statement]--90 million annually for improvements to the region's health care system. This is a compelling argument, one that we're asking you to consider as you listen to information about this transaction. Thank you.

COMMISSIONER MIREL: Thank you, Ms. Gallant. And thank you for keeping it within the time limit. I appreciate that.

Our next witness is Gloria Corn. Ms. Corn.

STATEMENT OF GLORIA CORN

MS. CORN: This is a "lose" situation for the citizens of the District of Columbia.

[Applause]

MS. CORN: I have absolutely no doubt whatsoever that the hotshots from this corporation will make a lot of money, and some of the hotshots at Blue Cross will, too. But there is no doubt that everything that that woman said of how it'll help D.C. residents is a lie, a lie, and a lie. And I'm going to prove it now.

[Applause]

COMMISSIONER MIREL: Please, let's not have any demonstrations in here.

MS. CORN: First of all, may I--

COMMISSIONER MIREL: We need to give full attention, and honor what people are trying to say. So no demonstrations, please.

MS. CORN: First of all, how they say they'll have all of this money that politicians can use: I am sure that's very, very tempting for some elected officials. But the elected officials who do buy it are the ones who are nothing but bought-and-sold whores. And if you agree with it, that's all you are, too.

The reality is that the money that they say will be made available, out of the 90 million, assuming the District gets one-third, that's 30 million. That's not a whole lot; not for the District of Columbia.

Could you please let me finish my statement?

That is not a lot of money. And all the

benefits that they claim that they can give could be gotten right now under Firstcare [sic] Blue Cross/Blue Shield as a not-for-profit. Not-for-profit is not the same thing as charitable. "Not-for-profit" means that there are no stockholders, and it's just the board of directors who decides how many people to hire, what they'll be paid, including themselves.

I have no doubt that if you go over how much Blue Cross/Blue Shield currently pays its board of directors, Mr. Jews, and who it hires and how many people it hires to do their jobs, and you put that in a business-like setting where profit was the bottom line, you could cut about a third of the employees, at least, at Blue Cross.

I know, as a person, as an individual, the kind of things I run across with Blue Cross/Blue Shield. I'll call them and ask them to send me a copy of my policy. That'll take four different times, till they send out the right policy--four times. I'll ask them to pay a doctor's bill, like chief of orthopedics at Georgetown or G.W. These

are not exactly unheard-of practitioners. That might take two, three months.

They have hired a lot of their friends, their buddies, their family--God knows who else--who are incompetent and incapable. If you cut out that fat, and if you, the insurance commission, made them adhere to a certain standard whereby they could not spend more than 20 percent of the income of what they get--or even better, a set dollar amount per policy--on administration and pay-outs, and the rest had to be used for medical bills, to pay medical bills, or for community things, you'd get every single thing this company is offering you, and then some.

You have to be more vigilant. You need to do your jobs better, because you haven't done it. It's that simple.

And that's all the money they're going to claim that they generate? That's nonsense.

Now, I'm going to just tell you something. They say that they'll be able to offer PPOs or HMOs to people who couldn't qualify for pre-existing?

Blue Cross offers that right now. They have open enrollment for PPOs for people who wouldn't qualify medically. That's how I got into the program.

I have multiple sclerosis. Who wants to insure somebody like me? Nobody. I wouldn't even. I got into this program in August of '96: $97 a month. Five years later, I'm paying 282 a month. That's almost a 300 percent increase in five years.

They claim that the cost, the COLA in the U.S. and in Washington is between 2 and 5 percent per annum. If you read the health care news, they'll say health insurance goes up between 13 and 18 percent a year. But this has obviously clearly gone up more like 50 percent a year for me.

In addition, where when I started I had unlimited medicine and a co-payment of $5 for non-brand-names, and $10 for brand-name drugs, now I have a cap of 1,500 a year--which I hit by the end of March, generally--so that I'm still paying out-of-pocket three to five thousand a year in medicine. And that's after I pay everything else. And my co-pays have gone up to ten for generic

drugs, and 20 for non-generic drugs.

So if you look at it realistically, that means I am currently paying about 800 to 1,000 percent more than I did five years ago, for the same plan. If it continues like this, under either them or these people who want to buy it, I will be forced to not buy insurance at all. And then I'll be on the public dole. And I will be getting either Health Care Alliance, or whatever else is established. And the citizens of the District of Columbia will be picking up my tab, instead of me. And if you think that that isn't going to happen, it is.

And I'm not the only one. Plenty of others are like me. We were middle- or upper-middle-class. We had plenty of money. Do you know how they say you should always have six months worth of salary stocked away in case you lose your job or this and that? Well, with something like multiple sclerosis, which hits in your earning years, you'd have to have 30 years worth of income stocked away. I had about ten years. It's not

going to go on forever.

And so here--here--everything this company is saying that they offered, you could get out of Blue Cross/Blue Shield right now by saying to them, "Out of every policy, you will only be allowed to spend, like $35 per month for administration of that policy." That's all you have to do. Make it--Just the way a charitable organization can only spend so much on administration, and the rest has to go to charity. Make them spend the rest on medical care for people in their plans, or to give back to the District Government to set up for free people.

You can do that. There's no law against it. But you haven't done it. And now you want to turn it over to these people who want--the bottom line is a profit? Do you honestly think that they're going to be looking at what's the best for--a doctor is not going to be put under the situation they've been put in?

And they use Georgia and--what?--Missouri as the basis of the glorification of this plan?

Good God! That's like saying the civil rights movement was born in Mississippi. Please. I'm not an idiot, and neither are the people sitting in this room who vote here.

Right now, under Blue Cross/Blue Shield, they don't guarantee a payment. When I broke and dislocated my shoulder, they wouldn't pay for a sling. They say that they have preventive care. Well, guess what? They wouldn't pay for a hepatitis prevention vaccine.

I have MS. The FDA has approved three drugs to slow the progression of this disease. I asked them, will they pay if I take Betaserone or Copaxon or Avenox. They say, "Well, after you get it ordered--" and it's $1,000 for a four-week supply, by the way "--then submit the paperwork, and then we will decide. And even if you went to see a regular doctor--" like the chief of orthopedics at G.W. or Georgetown "--that doesn't mean we're going to pay. We have to decide on a case-by-case basis."

You have not regulated these people; and

you should have been; and you should be now. And before you ever think of turning this company over where the bottom line is what really counts, you ought to be making sure that Blue Cross is doing everything it could and should be doing now, and then look at this proposal ten or 15 years down the road. Not now. They don't guarantee payments, in other words.

As I said, a for-profit institution is a business. It's to make a profit. And so they're going to make a little bit--Out of the big profit they make, they'll give back $30 million, assuming the 90 million is split equally between the three jurisdictions. Oh, and we should be so grateful for 30 million?

Do you think 30 million goes very far in this day and age? I don't know where you're living, because 30 million does not go very far. And while at the same time Blue Cross/Blue Shield is paying doctors less and less, and their executives are making more and more, and the patients are paying more and more and getting less

and less, if you think it's going to be turned around in a for-profit organization--corporation--I know you're not that stupid. It's just that you'd be that corrupt. There is no other explanation you could ever give.

They say about the location that the location isn't going to change. Are they going to keep the southwest address? I don't know.

I could go on and on. I think you get the drift of my point.

They may not even take people like me, if they go to profit, people who are seriously ill with diseases that--Let's be real: Unless there's some miracle, I'm going to get worse and worse and worse and worse, till I'm a total vegetable physically. I didn't do anything to get this disease. That's what makes me the angriest. Unlike people with HIV and AIDS, they participated in their own downfall. I did nothing. I had the wrong ancestors. But people like me--

COMMISSIONER MIREL: Ms. Corn, you have less than a minute.

MS. CORN: People like me, who will be very expensive to care for, congenitally constantly sick, constantly having more and more problems, they'll dump. And do you honestly think that $30 million is going to cover taking care of about 35,000 people who have MS in this city alone; much less, all the HIV patients, Lupus, Alzheimer's, Parkinson's, ALS? Should I go on? And then those who are just poor and uninsured. It's a delusion.

This is a lie. Don't buy it. And if you do, we'll know every single one of you has been bought and sold. Thank you.

COMMISSIONER MIREL: Thank you, Ms. Corn.

[Applause]

COMMISSIONER MIREL: Please. No demonstrations, please.

The next witness is Guy Durant. Is Mr. Durant here?

[No Response]

COMMISSIONER MIREL: If not, we'll go to Mary McCall. Is Ms. McCall here?

STATEMENT OF MARY McCALL

PAST PRESIDENT, METROPOLITAN WASHINGTON
PUBLIC HEALTH ASSOCIATION

MS. McCALL: Good evening. I'm Mary McCall. I'm a resident, a taxpayer, and voter here in the District. This evening I'm representing the Metropolitan Washington Public Health Association.

The Metropolitan Washington Public Health Association, MWPHA, is the local affiliate of the American Public Health Association. We are a membership organization of public health workers and advocates who live in and/or are employed in the metropolitan area.

MWPHA is also a member of the National Capital Area CareFirst Watch, and we support the comments that were made to your office on May 15th by DC Appleseed Center on the proposed case management order.

We do appreciate this opportunity to express our concerns about the CareFirst-WellPoint proposal which may have a very significant impact on health care in the District. We approach this issue as an organization that is committed to a

policy of universal access to health services for all, and to strong support for policies and programs in addition to health care, per se, that impact upon the health of our residents. That is, to name a few, clean air, clean water, safe and adequate food supplies, and housing, and adequate incomes.

We have decided, based upon the information available to us at this time, to oppose the proposed conversion. We take this position not because we necessarily support the current policies of CareFirst; but because we are very much concerned about further deterioration of the health services delivery and insurance system which leaves many people with inadequate and poor quality care.

We urge your office to play a strong role in the regulation of the proposal, including formulating questions about impact and commissioning sound research to provide empirical answers to those questions.

We would expect these questions to address long-term, not simply immediate, impact upon the

entire population and the overall systems of health care. And as your Maryland counterpart has done, we ask that you investigate the current compensation of CareFirst management and directors, and consider their financial incentives to propose and shepherd this conversion.

As other organizations this evening will describe, although over time CareFirst and other Blues have increasingly behaved in a way that resembles for-profit insurers, it is not in the best interests of the public to allow CareFirst to abdicate its original role as an organization motivated by non-profit values and local community interests.

At a time of economic downturn, when many are losing jobs and benefits and numbers of uninsured and under-insured are increasing, it is more important than ever to have a locally-controlled non-profit insurer of last resort.

We ask that your office investigate ways of encouraging CareFirst's management to live up to its mandate; not to eliminate that mandate.

CareFirst's retreat from the Medicaid and Medicare HMO markets in Maryland, and its apparent lack of interest in the District's Medicaid market, are not socially responsible positions. If this is the response of CareFirst as a not-for-profit, what might we expect if conversion is approved?

There is no convincing evidence that CareFirst must convert and sell or merge to remain viable. Rather, based upon several independent analyses, CareFirst has a good market share, an increasing number of subscribers, a good reputation relative to local competitors, and more than sufficient surplus. It's a viable organization.

In general, the available evidence indicates that health services and health insurers operated by for-profit organizations do not compare well with that provided by non-profits.

As the American Public Health Association has noted, conversions from non-profit to for-profit are associated with intense competition--primarily in terms of price--for market share, and competition for equity capital to finance

expansions; all of which engender pressure for major cost reduction and cost shifting. And it's delivery of care, not marketing and administrative costs, where the for-profit health insurers look for cost cutting.

The public health community has a particular concern here, in that anecdotal evidence in other areas suggests that for-profit insurers and for-profit providers may seek to shift costs for health screening and other preventive services to the public sector.

For example, local health departments, as does the District Department of Health, typically provide services such as immunizations, school health, STD and HIV testing, family planning, lead poisoning screening, breast and cervical cancer screening, to the general public. These are supported in large part by federal funds, and are primarily intended for those with very limited access to preventive health care.

But to the extent that an insurer or providers in a network do not offer these services

to their enrollees and clients, or that they under-reimburse for them, and instead, for example, recommend that their patients go to the local health department to get such a service, this puts additional stress on the public system, resulting in fewer resources for population-based prevention efforts.

Another area, as an example, in which for-profits generally tend to perform in a less socially responsible way is compliance with public health reporting requirements and cooperating with information and data for health planning on a systems-wide level.

From a stakeholder--rather than a stockholder--perspective, WellPoint's performance with regard to medical loss ratio, investments in infrastructure, and compensation to executives, does not compare favorably with that of CareFirst.

For example, the Maryland group Health Care For All used information presented in CareFirst's and WellPoint's annual reports to show that CareFirst's medical loss ratio is 90, compared

to 80 for WellPoint, over a three-year period.

As consumers, residents, and providers, it is in our best interests to have a higher proportion of resources spent on health services.

When decisions are made to spend less on health services, it usually results in a reduction in caregiver time that's spent with individual patients, substitution of less-skilled staff, reduction of staff overall, and reduced spending on supplies.

A for-profit company such as WellPoint is accountable to its stockholders.

COMMISSIONER MIREL: Ms. McCall, one more minute.

MS. McCALL: Okay. So I will leave this with you, so that you will see our other reasons for opposing this.

COMMISSIONER MIREL: You have a full minute. You can take it if you like. Okay.

MS. McCALL: Well, I'll stop here. Thank you.

COMMISSIONER MIREL: Okay. Thank you very

much, Ms. McCall. We will read the entire testimony.

Dr. Eliot Sorel.

STATEMENT OF ELIOT SOREL, M.D., PRESIDENT,

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

DR. SOREL: Commissioner Mirel, good evening. We welcome the opportunity to present our position on this very important decision that you're about to make. I'm here as the president of the Medical Society of the District of Columbia, representing 2,500 physicians, medical students; and also, speaking on behalf of our patients that these several thousand physicians serve.

We strongly oppose the proposed conversion and sale of CareFirst-Blue Cross/Blue Shield, for a number of reasons. We believe overall, though, this is going to be bad for patients, and bad for the community. And therefore, we are very clear in opposing it.

The reasons for opposing it are the following:

If CareFirst is allowed to become publicly

traded, the dollars that should be spent on patient care will be diverted to the stockholders. We know that as independent not-for-profit Blues plans have consolidated and gone for-profit elsewhere, the amount of money spent on health care has diminished, as the lady testified before me.

Where does it go? Usually, it goes into the pockets of the stockholders. As the costs of critical technology and pharmaceuticals rise, any decline in dollars spent on patient care can spell disaster.

Second, decisions about our region's health care here have to be made here. I think Washington, D.C. is a very special community. I don't believe there is any other community like it anywhere in the United States. And no one living in California knows exactly what is needed here. We, the patients and the doctors of this city, know best what is needed here.

We have a tough time even now with Blue Cross/Blue Shield. It will be even a tougher time, should it be involving companies far away.

Three, despite its claims to the contrary, CareFirst does not need WellPoint, or Wall Street, for their capital needs. CareFirst already is the predominant carrier here, and they have more than $700 million in reserves.

Four, any foundations funded by a one-time distribution of the estimated value of CareFirst would not serve the public interest in the long term. I think the suggestion of looking at the projections long term that was made earlier is very important.

It is this issue about which the Medical Society is most emphatic, Mr. Mirel. We urge you not only to deny CareFirst's application to go public, but to require that it behave like the insurer of last resort that for years it has been required to be by law, but has not been in practice. If legislation is needed to accomplish this, so be it.

It's interesting that the chief executive officer of the Blue Cross company local, William Jews, said recently, "We have not been, nor are we,

the insurer of last resort." Quite frankly, my colleagues and I were surprised that he finally admitted what we have complained about for years.

After all, CareFirst has yanked its coverage of individuals and small groups, shut down its HMO for Medicare patients, walked away from its HMO for Medicaid beneficiaries--All of this while instituting double-digit premium increases and amassing a staggering $700 million in reserves.

I was not only surprised by his admission, I was appalled, because CareFirst and the companies it comprises have for years been sheltered from paying millions and millions of dollars in income and premium taxes in exchange for serving as the insurers of last resort. Yet Mr. Jews brazenly states, "We have not been, nor are we, the insurer of last resort." In this quid pro quo scenario, CareFirst got the quid; but where is the quo?

One final comment before I close: Mr. Mirel, I believe you are an honorable man and will proceed with intelligence, energy, and good intentions, as you continue through what will no

doubt be an exhaustive and exhausting process.

I also believe that you can do only what the law allows you to do. And we believe that D.C. laws governing the conversion are inadequate to ensure that the decision you ultimately make will be profoundly based in what is in the best public interest.

I believe that our community would benefit from--and that therefore you would welcome--and I'm certain our community would benefit from legislation which would strengthen and more clearly define your role in this and likely future applications for conversions and sales.

We therefore support legislation, draft legislation, that would, among other provisions, place higher standards for approval of such a conversion and sale. The Medical Society is an active participant in the CareFirst Watch Coalition, and will work with the D.C. Council to ensure passage of such legislation.

In closing, because health care premiums should be devoted to patients, and not to

stockholder profits; because health care decisions should be made locally; and because CareFirst does not need an infusion of funds from California or Wall Street to remain healthy--even dominant--insuring this market; and because any proceeds from a CareFirst conversion and sale would not begin even to address the ongoing needs of persons requiring the presence of an insurer of last resort--For all of these reasons, the Medical Society of the District of Columbia believes that conversions in general, and this conversion sale in particular, are unwise at best.

But, of course, you don't have to take my word for it. It's there in the excellent Abell Foundation report authored by economist Carl Schramm. It's there in the words and actions of the Maryland General Assembly. It's there in the courageous decision by Kansas Commissioner Katherine Sebalius to deny the gluttonous Anthem Blue Cross/Blue Shield.

Simply put: Mr. Mirel, it's bad medicine. It's bad for our patients, especially for those

most vulnerable, who testified this evening. And it's bad for this community.

We urge you to deny the CareFirst-WellPoint application. Thank you very much.

COMMISSIONER MIREL: Thank you.

[Applause]

COMMISSIONER MIREL: Please. Please. No demonstrations.

Thank you, Dr. Sorel.

The next witness is Mr. A.G. Newmyer, III. Mr. Newmyer.

STATEMENT OF A.G. NEWMYER, III, CHAIRMAN
THE FAIR CARE FOUNDATION, D.C.

MR. NEWMYER: Good evening, Commissioner Mirel. I'm Terry Newmyer, volunteer chairman of The Fair Care Foundation. I am also a member of the steering committee of CareFirst Watch, and have recently been honored to be the first non-lawyer elected to the national board of The Appleseed Foundation. I appreciate my chance to appear, and my remarks represent the views only of Fair Care.

My prepared text describes Fair Care.

Among other things, we help people navigate the health insurance maze. Our case work heightened our interest in our local Blues plan. We remain startled, as we have been for years, at the stories we hear every day from consumers about how they're treated by the Blues, similar to what you heard this evening from Gloria Corn.

At least five years ago, we began to wonder: Where are the regulators? The public needs a strong regulator because market incentives obviously don't work with health insurance. Policy holders need somewhere to turn.

Tonight, we turn to you. We believe that the CareFirst-WellPoint proposal is an affront to the public interest that doesn't pass the "laugh test." And now the national press is watching, CareFirst is going to be the Olympic Games of conversions. The time has come to get it right.

Borrowing the title of the popular kids' TV show, I will offer three "Blues clues" to help DISR do it right. First, I urge you personally to study the record five years ago that led to the

merger of the plans in our region and the creation of CareFirst. I ask you personally to decide, with 20-20 hindsight, what was true and whom you now believe and trust.

The current application is not the beginning of a long process, as advertised. It's the final few chapters in CareFirst's multi-year scheme, described in the March 12th Washington Post article about Bill Jews. I quote, "He set it up to be taken over. The goal has always been the same: To become a for-profit company, and make himself rich in the process."

Permit me to paraphrase another quote, this one from Warren Buffett: To compare the regulation of our Blues plans to a sewer is an insult--It's an insult to sewage.

Nowhere has the sewage been more evident than in the Barry administration's review of the Blues' merger in 1997. But you decide. You read the record. Do you now believe it was a "merger"--a term studiously avoided at the time, since a merger is a form of conversion?

Do you now believe that the valuation snapshot was correct?

Do you now believe the testimony about how the top managers would stay in place? Was the ink dry on that transcript before Larry Glasscock took millions of dollars of charitable assets from the D.C. plan and went to Anthem?

Do you now believe that the conditions are being complied with?

Fortunately, your letter of May 21st to CareFirst's lobbyist puts a toe in the water of pointing out the many failures to comply with the conditions.

While you study what was said under oath, I urge you to focus on the testimony of the Blue Cross board members. They testified about the importance of remaining not-for-profit, under local control, and true to the historical mission. My, how they have changed their tune.

It does get a bit murky trying to decide whose sworn testimony happens to be true. If you believe that your predecessors handled the Blues

properly, please enjoy your reverie. Had they gotten it right, we wouldn't be here. CareFirst, born of regulatory sleight-of-hand, wouldn't exist in its current form.

Maybe you also believe that your colleagues in Virginia handled the Trigon matter properly. How could the Virginia regulators accept $750 million a few years ago as the value of the Blues, when the price now is $4 billion? Now, maybe the Blues managers are going to claim that they added $3-1/4 billion of value in a few years. But obviously, Virginia blew it, like so many other states. So if you think Virginia handled it properly, again, continue to enjoy your reverie.

Absent some understanding of where the truth lies, and absent historical context, there is no chance of getting it right this time.

Blues clues number two: My second suggestion is that you look in the mirror, and wonder aloud, as the consumer groups all do, whether you are sufficiently open-minded and independent to be the guardian of the public trust.

Sam Jordan of Health Care Now did us a service by touching on these delicate issues last week. When you told the Post, even before the CareFirst application was filed, that you had a hard time imagining why the proposal shouldn't go through, I believe your comment was truthful. I heard you explain on April 8th it was taken out of context. It may have been. I also think you were telling the truth.

I was floored by your e-mail earlier this month referring to the Maryland legislation as "onerous." Shall we shed a collective tear that the management of CareFirst can't get $33 million in bonuses for selling something they don't own? Or that WellPoint has to pay for its purchase with real money, instead of paper? Or that the burden of proof is on the applicants? What's so onerous about all of this?

Your April 4th letter to Chairman Cropp was similarly revealing. She asked if you would consider the extent to which CareFirst has been carrying out its charitable and benevolent mission

as required by charter. First you said you had no authority with respect to that charter because it's federal; despite the fact that the first condition in the 1997 merger order was that CareFirst must continue to be charitable and benevolent. Then you said that you have no evidence of violation, but you would investigate if you receive evidence.

Well, how about looking for it? If you were the chief of police, would you get rid of the patrol cars and wait for the evidence to be brought to you?

Then you told Chairman Cropp that the proceedings in other states had no specific instructional value. Well, we beg to differ.

And finally, with respect to the deficient and silly application filed by CareFirst and WellPoint with you months ago, your letter of May 21 asks some of the right questions; but I believe you should have held your hearing and denied the application.

Similarly, with respect to your request that the applicants file a draft amended

application, we do not believe it's your department's role to hold the applicants' hands and help them fine-tune their proposal. The public interest will be served when you say "No."

I've heard you speak of the twin responsibilities of your office to protect solvency and policy holders. Well, if the Blues' solvency is keeping you up at night, please go back to sleep. Reserves are reported to be well above requirements. CareFirst is earning about $100 million per year, even after the eye-popping payments to management, lobbyists, and so on.

The time has come to focus on the interests of consumers. You used to get paid to represent the insurers. This time, let's focus on the public interest.

So finally, let me outline a process that might help your department get to the right answer. The application cleverly acknowledges that CareFirst has been run more or less as a for-profit insurer and has taken steps to abandon its charitable, benevolent mission, as you've heard all

night. Now the applicants want to be rewarded for doing so by asserting that a conversion and merger wouldn't be a big change.

Here's the process that might work: Start by determining what, as a non-profit, CareFirst should be doing for health care consumers in D.C. If the company earns $100 million a year that's not needed for reserves and no longer needed to fatten up the company for purchase, then the profits can be invested in its charitable and benevolent mission across the jurisdictions.

Then, using methodology like the Pricewaterhouse study in Kansas, determine the likely impact on health access and care of WellPoint, given its obligation to shareholders and its profit margins.

Compare the two results. You'll begin to get the right answers.

Then, determine the right valuation for CareFirst. Mr. Mirel, if you believe that it's $1.3 billion, you are part of a very small club, indeed. Next, determine the expected yield on the

valuation and distribution for D.C. health care that would result from full valuation going into a foundation.

If WellPoint's acquisition would lessen health care access relative to a properly governed CareFirst--and we believe that's obvious--and if the foundation benefits for the residents are not obviously and demonstrably greater than the impact of a properly governed CareFirst, then the proposal is prejudicial to the public interest.

The phrase "properly governed" involves appropriate regulation and, importantly, a board and management team that wants to do what the Blues were chartered to do. CareFirst's board and management, in my view, has made itself clear.

You know, I love money, and I really hope that Mr. Jews and his colleagues go somewhere they'll be happy and make tens of millions of dollars each. I just don't want them to take charitable assets from the public to do it.

[Applause]

MR. NEWMYER: I'm almost finished.

COMMISSIONER MIREL: Please, you're cutting into the witness' time.

You've got one minute left, Mr. Newmyer.

MR. NEWMYER: Thanks. The applicants have done a clever spin job in the press of acting as if the Maryland legislature took away the big bucks for management. However, the bill outlawing the completing bonuses was a mere baby step. The big benefit and private inurement, of course, is in the employment agreements adopted just before the WellPoint deal was announced. These dollars make the $33 million pale by comparison.

As Mies van der Rohe said, "God is in the details." The exhibits to the Hay Group testimony give the details. The provisions for Mr. Jews and his colleagues are, I believe, unheard of, in terms of shifting charitable assets to private parties.

Our Corporation Counsel seems to prefer making no waves prior to his confirmation hearing for the bench. But to fail to challenge these contracts is sinful, in my view.

Two weeks ago, I called Dana Sheppard in

your office, and asked if the personal deals for CareFirst management had been submitted to DISR for review. Mr. Sheppard said that this is governed by fiduciary law generally, not by your office.

Three more sentences. Thank you.

Now, I know it's fashionable to ignore the conditions in the 1997 merger order, but keep in mind condition number 12, which says that you--you--have to review the executive comp. Tonight would be a good place to start.

The WellPoint proposal should cause policy makers throughout the mid-Atlantic region to wake up and return the company to its roots. Despite last Sunday's headline in the New York Times, the biggest prize in health care is not taking the Blues plans away from the public. The biggest prize in health care is decent health care.

Mr. Mirel, you should protect it, by saying "No" to CareFirst.

Thank you. I apologize for going over.

[Applause]

COMMISSIONER MIREL: Thank you. Please,

no demonstrations. No demonstrations, please. Respect the witnesses and what they say.

Thank you very much, Mr. Newmyer.

Next we seem to have a duo: Robert Malson and Ray Sczudlo. Are you both going to testify together, a tag team? What is this?

MR. MALSON: Yes. We will be testifying in tandem, Mr. Chairman.

COMMISSIONER MIREL: Okay. You're welcome. Please proceed.

TESTIMONY OF ROBERT MALSON, PRESIDENT,
D.C. HOSPITAL ASSOCIATION [DCHA];
RAYMOND SCZUDLO, CHAIR, AD HOC COMMITTEE ON
THE CAREFIRST CONVERSION, DCHA

MR. MALSON: Thank you very much. Good evening, Mr. Mirel. I'm Robert Malson, president of the District of Columbia Hospital Association. And with me is Ray Sczudlo. He is the vice president and chief legal officer of the Children's National Medical Center, and chair of the DCHA's Ad Hoc Committee on the CareFirst Conversion. Mr. Sczudlo is here tonight in that latter capacity.

Mr. Chair, due to the time limitations, I would ask that our entire testimony be included in the record, as if read. And we will summarize, in order to stay within the time frame.

COMMISSIONER MIREL: Yes. I appreciate that very much. We will certainly read the whole testimony.

MR. MALSON: All right. Do we get ten minutes each?

COMMISSIONER MIREL: We will give you ten minutes each, if you want to take ten minutes.

MR. MALSON: Well, we'll try to compress it. We'll do the best we can.

COMMISSIONER MIREL: Good.

MR. MALSON: By way of background, DCHA represents 18 hospitals, 16 in the District of Columbia and two in Maryland. Collectively, these hospitals serve the entire Washington metropolitan area, stretching beyond the District's borders well into Maryland and Virginia.

District hospitals employ over 22,000 people. They provide health care services to a

wide area of nearly two million people. Each year, District hospitals have over 155,000 in-patient admissions, over 70,000 ambulatory surgeries, and over 400,000 emergency room visits.

Most importantly, we estimate that about 15 to 20 percent of our patients--that is, about 23,000 patients, 11,000 out-patients, 55,000 emergency patients--are covered by a product offered by CareFirst Blue Cross/Blue Shield, including thousands of employees of the Federal Government and thousands of senior citizens who purchase CareFirst's Medigap policies to supplement Medicare. Thus, the fate of CareFirst Blue Cross/Blue Shield is of critical importance to all DCHA member hospitals and the patients we serve.

The DCHA board of directors, which consists of the CEOs of all of our hospitals, voted on December the 6th to oppose the CareFirst conversion to for-profit status and the merger with WellPoint Health Networks.

Their reasoning is summarized in a set of principles that were adopted the same day. I would

like to quote from that document:

"DCHA supports a region-based, financially viable non-profit insurer to work in partnership with consumers, health care providers, government, and business. This partnership is needed to offer attractive insurance products to employers and individual subscribers throughout the Washington metropolitan region, to maximize the availability of health coverage to the greatest number of individuals possible."

For District hospitals, this point cannot be over emphasized. Every year for the past decade, District hospitals have provided over $200 million in health care to the uninsured in our service area. That is $2 billion in ten years.

The original Blue Cross charter called on the insurer to meet the unique health needs of the greatest number of area residents. Conversion to a for-profit status will not accomplish this requirement, and our hospitals have a very real concern that the care they provide to uninsured individuals will only increase if CareFirst has to

pay part of its revenue to stockholders. We have already witnessed a shrinking of available insurance products from CareFirst. It is unlikely that a conversion and a merger will improve that situation.

The result of our concerns would be one of several negative consequences: increase in premiums, or reduction in provider payments.

If the deal is approved, CareFirst will be forced to focus on its stockholders and their satisfaction with the company's profits. The easiest way to ensure higher profits is to raise rates, or cut services, or a combination of the two.

While company officials have stated in various public fora that premiums will not increase, they have been unable to explain how the conversion and merger with WellPoint will provide the necessary benefits to stockholders. Although the merger appears to indicate that the economies of scale will be possible, CareFirst officials testified before the Maryland insurance

commissioner that there would be no consolidation of offices and no reduction in the number of CareFirst employees. Thus, it seems that there will be no economies of scale; and thus, no savings.

The only way to provide benefits to shareholders will be by raising premiums for beneficiaries. The burden of such premium hikes will be on business and the beneficiaries. The cost of premium increases can result in a loss of insurance for low-income workers, either because the worker can no longer afford the premium, or because the business can no longer afford to pay the premiums for the workers.

Additionally, it may also be that, while insurance is paid for by the employer, the employee may not benefit from the insurance because of the increased cost of deductibles and co-payments.

There will be another way for CareFirst-WellPoint to make enough profit to benefit stockholders, and that is by reducing payments to providers. For our District hospitals, whose

aggregate operating margin hovers below zero, this would be a disastrous decision. If payments to providers are reduced, this would jeopardize the hospitals' ability to continue to provide $200 million in care to the uninsured. Access to care would be limited, and the very viability of a fragile hospital community would be in doubt.

Almost 20 percent of the District's population is uninsured. Strides have been made in the past two years to enfranchise more people in public programs. We congratulate the District Government for expanding the Medicaid program and for developing the D.C. Health Care Alliance to provide more coverage to previously uninsured individuals. That is great news.

Unfortunately, the bad news is that the CareFirst conversion and merger is likely to increase the number of uninsured who will be eligible for those programs, burdening the city with more people who will need to take advantage of Medicaid or the Alliance. The District is in precarious financial condition already. An

additional group of uninsured persons whose health care coverage would need to be paid for by the District could be the deciding factor as to whether or not the city remains financially viable. The Council of the District of Columbia already had to lead the fight to fund the Alliance fully for 2003. If more uninsured people are added to the eligibility roles, the Alliance will need additional funds.

While our DCHA board has expressed its opposition to the CareFirst conversion and merger, the board also noted that if the deal is approved in three jurisdictions, the value of CareFirst must be appropriately determined.

It is becoming clearer every day that the $1.3 billion deal is absolutely under-valued, for a number of reasons:

First, CareFirst has been the beneficiary of "favored nation status" among providers since its inception.

Second, CareFirst's non-profit status has provided special benefits for the company

throughout its history.

Third, CareFirst has not provided documentation of how the price was derived; only that financial advisors thought that it was a fair deal.

A comparison is helpful to understand the dollars now at stake for the D.C. residents. As you know, Anthem, the for-profit Blue Cross plan based in Indiana, has proposed to purchase Trigon, Virginia's for-profit Blue Cross plan, for nearly $3.8 billion. Trigon has one million fewer members than CareFirst.

Even before this pending deal was announced, DCHA was troubled by the $1.3 billion price for CareFirst; but this comparison raises even more concern. While there may be some differences that can account for some of the much higher proposed purchase price, we find it very difficult to believe that there is a $2.5 billion difference between the two plans; especially one that is only two-thirds the size.

We strongly urge you to have the CareFirst

application scrutinized by experts who can determine the real value of the plan, accounting for its non-profit history, understanding the intangible asset of the "Blue Cross" brand name, and comparing the recent deals in other jurisdictions.

In addition to the appropriate evaluation of the worth of CareFirst, the DCHA board has been emphatic about the need for an effectively developed health foundation to receive the funds if the deal is approved.

Maryland has had such a foundation for several years. We all watched with many misgivings about the machinations regarding the tobacco monies. Without a specific health foundation, the limited benefits from the sale of CareFirst could disappear, in the same way that the residents of the District lost the potential benefits from the tobacco settlement.

Our board believes that the District cannot have a second incident of health care dollars being lost to the public good. While we

understand that the Corporation Counsel has the primary responsibility for setting up the foundation, if the deal is approved, we urge you to follow the dollars very closely, so that those for whom they are intended actually do receive the benefit.

I would now like to turn the balance of our testimony over to Mr. Sczudlo.

COMMISSIONER MIREL: Thank you very much, Mr. Malson.

Mr. Sczudlo, you have a full ten minutes, so please proceed.

MR. SCZUDLO: Thank you very much, Mr. Mirel. My name is Ray Sczudlo. That's spelled S-C-Z-U-D-L-O--Bet you wouldn't have guessed it.

At this time, I would like to explore some of the key questions that arise in the application before you:

Is CareFirst in Need of Rescue? While it is true that a number of independent Blue Cross plans have become less than independent, the enrollment in the Blues has grown by almost 17

million since 1994. There are currently 45 independent Blue Cross plans operating across the nation, down from about 67.

Most of the mergers and acquisitions between and among the Blues occurred when the plans were in financial trouble or on the verge of bankruptcy. This is not the case with CareFirst.

According to the study conducted by Carl Schramm for the Maryland-based Abell Foundation, CareFirst has ample reserves that exceed the minimum established by the National Association of Insurance Commissioners by nearly 500 percent. A conversion to for-profit is not necessary to protect either the company's assets or its market position, now or in the foreseeable future.

Is the Conversion in the Public Interest? A lot has been said since the filing about whether the proposed conversion and merger are in the public interest. What goes into determining the public interest?

Well, let's look at the money. When a company becomes a for-profit entity, it is duty

bound to pay attention to its stockholders. This fact of life is simply not in the public interest in this case, because it has to divide the pie into three pieces rather than the two that currently exist. As a non-profit, CareFirst pays providers with the majority of its premium dollars, and uses the remainder to pay for administration such as billing, claims processing, and the like. As a for-profit corporation, CareFirst will be duty bound to put shareholder value--that is, profits--at the very top of its list. In real terms, this means that the smaller percentage of premium dollars will go to health care.

At the present time, not-for-profit CareFirst spends 88 percent of its total revenue on health care services. For-profit WellPoint, the proposed acquirer, spends only 75 percent of its revenue on health care services. The difference is what goes back to stockholders. And I ask you: Is this in the interest of the residents of the District of Columbia? Is this in the interest of the hospitals and physicians who provide health

care services to the residents? Is this in the interest of the residents themselves? The answer, we believe, clearly is: No.

DCHA believes that the burden of proof in any transaction that will have an impact on the community should be on the applicant. It should not be your responsibility to prove a negative. The DCHA board is very clear on this point. It is up to CareFirst and to WellPoint to show that the change in status of the largest insurer in the District, Maryland, and Virginia will positively affect the community. Failing this, the application must fail.

The DCHA board's principles emphasize the need for the region to have a non-profit insurer who works in partnership with the providers to ensure appropriate reimbursement, so that the providers can continue in business to provide health care.

At no time in our history is a partnership with a non-profit insurer more important than now, with the closure of two hospitals within the

District within the past year, and with the growing number of patients without any type of insurance.

During its first 50 years of life, the old Blue Cross of the National Capital Area worked closely with those hospitals most burdened by the uninsured, to make sure that they would remain financially viable--again, to continue providing care. Unfortunately, CareFirst has not been this type of partner for many, many years.

DCHA believes that an insurance plan that places the interest of stockholders before beneficiaries will only jeopardize further the health--and perhaps the very existence--of hospitals, whose collective mission is to serve the community.

Before I close, I would like to point out two very important District-specific issues which require your attention as well as the attention of the Council, the Corporation Counsel, and every resident. These issues have significant bearing on how the District and its residents and providers could be negatively affected if the deal is

approved.

The first issue is valuation. Mr. Malson and others tonight have spoken of this, but the valuation must be adequate for the losses that will be incurred by residents and providers in the District of Columbia. The important point here, that goes further than what has been stated, is that there are, of course, three separate plans.

There is one plan before you. The sale price--the 1.3 billion that is referred to--is supposed to be an all-encompassing amount to cover these three components. This price tag in the aggregate, we believe, is seriously under-valued. But it's very important to separately value and look at the plan in front of you.

The CareFirst plan in the District of Columbia--Group Health and Medical Services, Inc.--not only includes beneficiaries in the District, in Maryland, and Virginia, it is the most profitable of the three plans in CareFirst, and has the highest reserves of the three: some 260 million, compared with Maryland's plan reserves of 234

million, and the Delaware plan's reserves of 84 million. The per capita revenue enjoyed by CareFirst from the District's plan is significantly higher than that of Maryland or Delaware. You must not overlook this in the valuation process. It is critical that you have a separate and complete valuation of the D.C. plan.

In addition, rate setting in Maryland puts the District of Columbia and Delaware at a great risk. As you know, Maryland insurers, no matter who they are, pay the same rates to individual hospitals for the same care. Maryland is the only state in the country with such a Medicaid waiver allowing such a financing mechanism. The Maryland Health Services Cost Review Commission sets the rates that must be paid by every insurer in the state; no negotiation allowed.

Thus, even if the conversion/merger is approved in all three jurisdictions, CareFirst will be required to continue to pay the same rates to Maryland hospitals as every other insurer. This doesn't apply to the District. So harking back to

the fact that there's now three claims on CareFirst money, keeping in mind that they cannot squeeze the providers in Maryland, that leaves the providers and the rate payers in the District of Columbia.

If we want to keep the volume of CareFirst patients in the District, we would be forced to accept lower rates. It puts the District hospitals at a distinct disadvantage vis-a-vis Maryland hospitals. The viability of the city's institutions will be placed further in jeopardy, and access for all District residents, not just the uninsured, may become problematic. Thus, the acquisition here will not resolve this problem. And as a result, it should be a key factor in your decision.

There are, of course, many other questions, so many questions that are raised by the application. Just to touch on a few additional questions:

How will CareFirst officials assure you, Corporation Counsel, other city officials, providers, and the community, that the

conversion/merger will not result in higher premiums and decreased provider reimbursements? Or more precisely, I think the question is, how will you enforce this?

What protections will be afforded to subscribers to prevent cancellation and coverage denials?

If, as was testified before the Maryland Insurance Commissioner and tonight, CareFirst will not lose any employees or close any offices, in order to remain local, how will these economies of scale be achieved?

What local leadership will the District's plan have if the conversion/merger is approved, and how will the leadership be answerable to the public interest?

WellPoint has a poor reputation with providers in California, according to a hospital association survey. How would it be any different in the District of Columbia?

Why should the majority of the capital claimed to be needed by CareFirst be directed

towards further acquisitions, as is stated in the Accenture report, when CareFirst is already the largest health insurer in the region?

There are many questions, as I've said.

COMMISSIONER MIREL: You've got one more minute, Mr. Sczudlo.

MR. SCZUDLO: It is clear to hospitals and patients that the proposed conversion and merger is not in the public interest. It will make it more difficult for individuals and employers to get health care coverage, and it will put already financially frail provider institutions in serious jeopardy.

A non-profit insurer is a key to comprehensive health care delivery that will meet the needs of Maryland, D.C., and Delaware communities. Thank you very much.

COMMISSIONER MIREL: Thank you, Mr. Sczudlo. And thanks to all of the witnesses for being so careful about time. I really do appreciate it.

The next witness is Steve Gammarino. Mr.

Gammarino?

STATEMENT OF STEVE GAMMARINO

BLUE CROSS/BLUE SHIELD ASSOCIATION

MR. GAMMARINO: Good evening. I'm Steve Gammarino, senior vice president at the Blue Cross/Blue Shield Association. And I thank you for the opportunity to appear before you to discuss the proposed merger of CareFirst and how it relates to the Federal Employees Health Benefits Program.

Blue Cross/Blue Shield plans jointly underwrite and deliver the government-wide service benefit plan in the Federal Employees Health Benefits Program. The service benefit plan has been offered in the FEHBP since its inception in 1960, and it is the largest plan in the program. The service benefit plan currently covers approximately four million federal employees, retirees, and their families.

CareFirst insures about 14 percent of all lives covered under this health plan. CareFirst has the largest federal employee enrollment of the Blue Cross/Blue Shield companies participating in

the service benefit plan. For calendar year 2000, CareFirst processed nearly seven million FEP claims, for 281,000 contract holders.

These numbers demonstrate leadership among the Blues, which are the number-one choice for federal employees both in the District and around the nation. CareFirst has 845 employees fully dedicated to administration of the federal employee program.

CareFirst recently received two honors from the association: the coveted brand excellence award, and the high performance-low cost award for its handling of the federal employees program. The brand excellence award is given to plans that demonstrate traditional brand strengths while providing exceptional customer service and solid business performance.

This was the fourth consecutive year CareFirst was selected for the FEP high performance-low cost plan award which honors member plans that provide excellent service to enrollees.

The success evidenced by the numbers I've

just cited tonight shows the strengths of CareFirst in the federal employee program.

The participating Blue Cross and Blue Shield plans follow a variety of business models including not-for-profit, for-profit, and mutual companies. Within the Blue Cross/Blue Shield system the local plan determines the business model. The association sets standards local plans must meet regardless of the business model chosen.

Our experience has shown that selection of a particular business model will not affect a plan's operation or enrollee satisfaction. Therefore, we expect continued high levels of service to federal enrollees, should this transaction be approved.

The Blue Cross/Blue Shield Association has been in partnership with the federal employee program for more than 40 years. We have seen our enrollees consistently endorse the Blues generally, and CareFirst specifically.

CareFirst service award winning and its dedicated employees are a key part of the service

benefits plan's enrollee support system. CareFirst is a strong performer, and the association believes the proposed conversion and merger will not change that. Thank you.

COMMISSIONER MIREL: Thank you very much, Mr. Gammarino.

The next witness is Todd Miller. Is Mr. Miller here?

MR. MILLER: Yes.

COMMISSIONER MIREL: You may proceed.

MR. MILLER: Thank you, Commissioner. Good evening.

STATEMENT OF TODD MILLER

EMPLOYEE BENEFITS BROKER

MILLER AND SHOOK COMPANIES

MR. MILLER: I'm Todd Miller, and I work in Washington, D.C., as an employee benefits broker for the Miller and Shook Companies. I've been working in this regard for about seven years now, having taken over my father's book of business that he began with the Blues back in the '70s.

As part of conducting my business, I've been following the progress of the CareFirst proposed conversion for the for-profit status and the merger with the WellPoint Health Networks.

My clients, obviously, are my primary concern, as a professional in health care and insurance, and I'm interested in the potential benefits for the small business enterprises, my customers. In fact, my client base is primarily made up of associations and not-for-profits who employ between two and 50 people. So small business health insurance coverage is, in fact, my livelihood. And these organizations are also

important to our community.

CareFirst is committed to serving the small business market, and to growing it. Providing health care benefits is critical to attracting and keeping good employees and a healthy local economy. And CareFirst is the industry leader, I believe, in that market.

My attitude towards the proposed conversion and merger is that it affords an opportunity to combine the best of all worlds. I know WellPoint very well. Its UNICARE division is a very strong competitor of ours, with outstanding product offerings for groups for more than 50 people. CareFirst has an outstanding product for groups two to 50. If these two companies merge, they will have the highly competitive coverage of the entire small business arena.

This prospect seems to me to be good for the company, and good for competitive coverage and for pricing in the D.C. community.

Let me tell you a little bit about what my clients need, and what I try to provide. Small

businesses in this day and age worry about attracting and keeping good employees, and they worry about their costs. The CareFirst Blue Preferred PPO for small business is by far the best product, hands down. In the District marketplace, from that standpoint, there's not another carrier that probably comes within 20 percent of their pricing.

For that reason, the CareFirst Blue Preferred PPO is about all that I sell. The coverage is outstanding. It's a network of physicians that include almost any doctor a person might be able to go to, and provides a person the ability to self-refer to a specialist without the use of gatekeepers.

And it's a Blues product. The "Blues" name carries a lot of weight with the customers and the employees. The area needs a strong Blues company that is competitive with other national insurers that operate in our region. Strong Blues will preserve the proposed conversion and the merger.

Plus, as a broker, I like the fact that we've been doing business with the same insurance company for so many years. As I mentioned, my father began the business about 20 years ago, in dealing with Blue Cross and Blue Shield of the National Capital Area.

CareFirst has continued to sell through brokers, which we're particularly grateful for. The company has been a very good partner of ours. And the merger turned a previously weak Blues plan in Maryland and D.C. into a strong consolidated Blues company. Affiliation resulted in more than 4.4 million in savings through reduced administrative expenses, vendor consolidation, and improved profitability.

CareFirst has said that this merger could be good for our community, in terms of better customer service, more choices in insurance product, and a slower rate of increase in health insurance premiums.

The merger also provides an opportunity to invest millions of dollars for the sale into

charitable foundations that could meet some of our community's unmet health care needs. Across the country, such trusts are proving to be effective tools for addressing society's health care needs.

About 139 groups exist, with more than 15 billion in assets, disbursing more than 750 million a year.

The potential good for our community should be carefully thought through. And the established process, which includes hearings like this one, will help to do that. Thank you for your time.

COMMISSIONER MIREL: Thank you, Mr. Miller.

Ms. Ethel Weisser. Am I pronouncing it correctly? Okay. Ms. Weisser, do you want to stand, or would you rather sit?

MS. WEISSER: No, I'll be fine over here.

COMMISSIONER MIREL: Okay.

STATEMENT OF ETHEL WEISSER

GRAY PANTHERS OF METROPOLITAN WASHINGTON

MS. WEISSER: My name is Ethel Weisser, and I represent the Metropolitan Area Gray

Panthers. Also with me are two other members of the board of trustees, and that is Rosemarie Flynn, who really is acting chair, and Geraldine Britain, who is our treasurer.

I would like to take this time to commend the Metropolitan Washington Public Health Committee [sic] for its wonderful pertinent statement, and also a lot of the remarks of Mr. Newmyer of the Fair Care organization.

I've lived a long time, and I've seen enormous changes in the health care delivery system. And I think the most significant, big look at health care delivery started in the 1930s. That's when you had the organization of trade unions who then began to negotiate with their employers for health care benefits. So you begin to have also the connection between health care benefits and trade unions.

In addition, the large--including maintenance workers and ship-building workers. Kaiser ship-building plans were started. Group Health was started as a medical co-op. Puget Sound

Medical Co-op was started. Any number of small organizations--The mine workers, for example, set up their own clinics, and withdrew from what were then the offerings of the organized medical profession.

In addition, it was Blue Cross that was started in 1937. It started with federal funding. The 1930s were the years--as I say, with the New Deal legislation and Franklin D. Roosevelt as President--when health care became on the American agenda. And federal money--and I think some state money, as well--was put into the formation of Blue Cross. Blue Shield didn't start until two and a half or three years later. And again, it started with federal funding.

The health care industry has never been financially independent. The Hill-Burton Act built most of the hospitals in this area. And then, of course, as we came to the '50s, we began to have the conversion to HMOs; to the intrusion of insurance companies on decisions of health care making; and the kind of what is now the terms used:

"markets," "products." I mean, when I hear of a "health care product," I feel like a stock issue or something, you know, other than a human being. And yet, the whole purpose of medical care is to take care of people.

I mean, this is an American need. It's like breathing air. We all need medical care. It is certainly out of the ordinary to introduce profits to an entity like taking care of the public.

And one of the things, for example, in the District that has made this such a bad area for health care delivery is the infant mortality rate. We're still--The United States is still pretty high on the infant mortality rate for the world. And the District particularly has had that problem for a long time.

So here we are, dealing with not only the conversion to profiteering by Blue Cross and Blue Shield, which it has done anyway--Blue Shield and Blue Cross were the first to throw out its Medicare-Plus plan; throw an enormous number of

people out onto the market, if you will, to find new places. And thank goodness that Kaiser Permanente took them in. And Kaiser Permanente is still a non-profit. I hope it stays that way. And though it is part of big medical care delivery--I mean, plenty of insurance and benefit restrictions in the Kaiser Permanente plans--it is still non-profit. And there's still hope for the reintroduction of an ethical standard in the medical profession.

I think this is something that we have to really cope with. And I'm hoping, Mr. Mirel, that you will take into account that health care is not a for-profit kind of industry. It is not an industry, to begin with.

It does, it's true, take many years of study and practice to become a very good physician. But it doesn't take that long to be a good administrator, or a CEO operator, to siphon off the kind of funds.

And I am seeing, with the development of WellPoint taking over--Again, as a matter of fact,

in hearing after hearing on the Hill, in hearing after hearing in the local area jurisdictions, we decry the influence of insurance companies in making health care decisions. We want the doctors to make the health care decisions. We don't want insurance companies. And to allow that to happen here, and to allow profiteering in this kind of area of public concern, is really an obscenity.

And I think it's time that you stood for the ethics, the appropriate ethics, involved in delivering health care.

We are giving you a statement that will expand our position a little bit more. But I think it's time that the authorities in the D.C. Government, as well as elsewhere--and a little bit more has been done in Maryland than here in D.C.--reintroduce what is an ethical program, a non-profiteering kind of program; one that doesn't suck money from the American public in the way that doctors have so far and the plans have so far. Thank you.

COMMISSIONER MIREL: Thank you.

[Applause]

COMMISSIONER MIREL: Please. Please. Please.

Thank you, Ms. Weisser. And thank you in particular for that brief history, which is very helpful. Especially when you lived through it, so you can talk from direct experience. I appreciate that.

The next witness is Rolando Andrewn. I'm not sure I'm pronouncing that correctly. Andrewn? Mr. Andrewn, please come to the podium.

STATEMENT OF ROLANDO ANDREWN
EXECUTIVE DIRECTOR, AMERICAN LUNG ASSOCIATION
OF THE DISTRICT OF COLUMBIA

MR. ANDREWN: Thank you. They usually don't make these mikes tall enough for somebody 6'9". We'll make adjustments.

COMMISSIONER MIREL: Mr. Andrewn, would you prefer to sit down?

MR. ANDREWN: No. I'm perfectly fine standing up.

COMMISSIONER MIREL: Okay.

MR. ANDREWN: And I want to bring greetings from the American Lung Association, and from Dr. Bailus Walker, our board chair. And as we say, when you can't breathe, nothing else matters.

And I'd like everybody in here to take a deep breath--and exhale. Very good. That sort of eases things.

And the American Lung Association, now in its one hundredth year, is here to testify and provide our support for CareFirst's conversion. And let me tell you why we are supporting this.

First, I want to talk a little bit--And again, you have the testimony, and I will expand some of my testimony. First, I want to talk a little bit about the existence of major health needs in Washington, D.C.; in particular, health needs that deal with lung disease such as asthma, chronic bronchitis, emphysema, lung cancer.

And unfortunately, D.C. ranks very high in many of these diseases. And it's high time that we start making moves and start making strides towards addressing some of these issues. And the American

Lung Association has been doing so, at least since the last one hundred years; especially dealing with tuberculosis, and now dealing with the asthma epidemic with the creation of D.C. Asthma Coalition.

I want to say that CareFirst has supported our efforts by providing a $30,000 grant to the American Lung Association to carry out its "Open Airways for Schools" program; a program which is very much needed in the third- and fourth-grade levels, where kids are suffering from asthma and the asthma problem is running rampant in terms of mismanagement.

So the American Lung Association, through this grant, has been able to introduce the program to many schools in the District, and has been able to graduate kids in the third- and fourth-grade levels in "Open Airways." As a result of this, the outcome is that kids who have gone through the program have missed less school days; have missed less time going to the emergency rooms with their parents; which indeed translates into success and

more productivity for these kids.

CareFirst is also in discussion with us toward supporting our second annual D.C. Asthma Walk, "Blow the Whistle on Asthma," which is going to be held at the National Mall on September 28th.

So in terms of supporting the Lung Association and its efforts to combat lung disease, CareFirst has been a corporate citizen and been a supporter of our efforts.

Now, let me turn to the conversion of CareFirst and purchase by WellPoint Health Networks. As this purchase happens, it will create a trust fund of over $400 million. The interest on this trust fund will be used for much-needed services, programs, and interventions in the community.

We're looking at tens of millions of dollars going into the community to address problems; not only in asthma, but things like problems such as diabetes, cancer, Hepatitis, you know, all sorts of different issues that exist and that are not being properly addressed today.

So we are in support of this conversion, because we believe that with this trust fund we can make a difference. Unfortunately, we had the misfortune of having the tobacco trust fund not being properly distributed. Hopefully, we can get at least $2 million this year from the trust fund towards addressing tobacco issues.

But just imagine, if we have $20 million addressing issues of health in the District. Imagine the infusion that will make, in terms of the problems that we have. We, unfortunately, rank last in many, many different categories, and we wonder why. Well, some of the reason may be attributed to lack of proper health care. And again, this will help to make that happen.

And so, I'm in support of this conversion, and hopefully, you will decide equally. Thank you.

COMMISSIONER MIREL: Thank you very much.

The next witness is Winifred Williams. Is Ms. Williams here?

[No Response]

COMMISSIONER MIREL: If not, JoAnn Pearson

Knox? Welcome, Ms. Knox.

MS. KNOX: Thank you.

COMMISSIONER MIREL: You have to pull it down [referring to the speaker's microphone]. Six-foot-nine is pretty tall.

MS. KNOX: Yes. I have a hard time competing with that.

STATEMENT OF JOANN PEARSON KNOX

NORTHERN VIRGINIA ACCESS

TO HEALTH CARE CONSORTIUM

MS. KNOX: My name is JoAnn Pearson Knox, and I am privileged to be the co-chair of the Northern Virginia Access to Health Care Consortium. And I'm here to remind you, as I'm sure someone did last week, that northern Virginia is a part of this, also.

Our consortium consists of over 40 public and private health care providers and consumers and local foundations that work on behalf of the uninsured and under-served populations in our jurisdictions.

Many of our members provide services--often in an

episodic manner--to some of the more than 200,000 northern Virginians who are uninsured. The best thing that could happen to us, however, is not more money to provide services to more uninsured persons. The best thing that could happen to us, and to northern Virginia as a whole, is a reduction in the number of people who are uninsured.

Anything that may lead to greater numbers of persons being uninsured is bad for northern Virginians. Anything that can help reduce the number of persons who are uninsured would be good. Our experience supports those studies showing that it is comprehensive coverage and regular care, not episodic and urgent care, which makes a difference in health status and outcomes for people.

We were not surprised by the study released last week showing undiagnosed conditions, untreated conditions and illnesses, and substantial premature death for the uninsured. It is essential, therefore, to get more, not less, people insured.

In northern Virginia, few of the uninsured are unemployed or in families where no one is employed. Most are not in poverty. They are employed. They are hard-working. They have modest incomes. They are in the service sector, in construction, or owners of small businesses. Their employers do not provide them health insurance coverage. They have difficulty affording the coverage that might be available.

For these northern Virginians, concepts such as individual plans, open enrollment, and community rating may sound foreign; particularly if English is not their first language. But they are vital to providing an opportunity for health insurance. If these options are available, programs can be developed to increase insurance coverage in the region. Without them, it would be more difficult.

We recognize that often some conversions or sales of Blue Cross plans have included commitments or requirements to maintain some of the products that non-stock corporations have offered.

Those commitments and conditions, however, are time-limited. They do not carry over to the next sale. They merely delay when insurance options for those with the most difficulty obtaining it will be reduced.

We have some recent experience in Virginia, as you've heard. When Blue Cross/Blue Shield of Virginia converted to Trigon, one of the selling points was that it would remain a Virginia entity. Now it is proposing to be sold to Anthem.

When GHMSI merged with the Maryland Blue Cross plans, one of the selling points was that this merger would protect its status as a non-profit, and that there was no intention to go for-profit. Now we have the current proposal before us.

Regardless of good-faith commitments and conditions placed on any transaction, the conversion of CareFirst to a for-profit and its sale to WellPoint would risk long-term loss of a critical insurance option for those needing the system that a non-stock corporation provides.

It is virtually certain that over time it would be less likely that those not in a major group plan would have the type of affordable access to health insurance that they need.

I thank you for the opportunity to comment at this session, especially in view of the fact that we're not going to be able to make comments to the Virginia commissioner. As you know, the Virginia Commissioner of Insurance has determined that, because GHMSI is domiciled in the District, responsibility for approval or denial of this transaction is being deferred to you.

It is therefore critical--and we ask--for the wellbeing of northern Virginians and those in the District, that you request a thorough health impact study to be done, and that the study must include the impact this sale will have on lives of northern Virginians. Thank you.

COMMISSIONER MIREL: Thank you, Ms. Knox.

[Applause]

COMMISSIONER MIREL: Please. Please. And Ms. Knox, as I told your colleague last week, I am

very mindful of my responsibility to the people of northern Virginia who are GHMSI policy holders, and I will give them all the care I'm giving to people in the District of Columbia. So thank you for coming here tonight.

MS. KNOX: Thank you.

COMMISSIONER MIREL: The next witness is Walter Smith. Mr. Smith.

STATEMENT OF WALTER SMITH

D.C. APPLESEED CENTER

MR. SMITH: Good evening. I'm Walter Smith, Executive Director of the D.C. Appleseed Center.

D.C. Appleseed's essential position remains as it was when we submitted extensive comments to you in our March 6th letter. That position is that you should not approve the proposed conversion and sale of CareFirst, unless CareFirst and WellPoint show that their proposal is in the public interest.

Our view is that they have not come close to making that showing. In fact, our view is that

they have not established any of the three key propositions that they advance in their January 11th filing with you:

First, that CareFirst needs to convert and sell itself to remain viable;

Second, that the conversion and sale will have a positive impact on the availability, accessibility, and affordability of health care coverage in the National Capital area; and

Third, that any harm from the sale and conversion will be more than compensated for by a foundation that will receive the D.C. plan's share of the 1.3 billion sales price for the company.

Now, we take it, from your May 21 letter that you sent to CareFirst, that you're largely in agreement with the position we have advanced. And then you directed CareFirst and WellPoint to submit detailed evidence supporting their key propositions when they file an amended and restated application in July.

In light of your May 21 letter and other recent events, what we would like to do now is add

some suggestions to you concerning steps you might take beyond those in your May 21 letter. And if I don't get through all of them, you'll have it in the written testimony.

First, in light of the $4 billion bid Anthem has made for Trigon, and the obvious impact that bid has on the fair valuation of CareFirst, we think you should consider directing CareFirst to demonstrate how its valuation analysis is affected by the Trigon-Anthem deal.

Second, in light of the sworn testimony from the chair of the CareFirst board at the recent hearing before Commissioner Larson--which I believe Ms. Gallant repeated tonight--that the proposed transaction--and now I'm going to quote from the testimony--"will slow the rate of increases in premiums," you should specifically direct that evidence supporting that claim be included in the amended filing.

Third, in light of Accenture's crucial claim that WellPoint would be unable to raise premiums after the conversion and sale because it

would lack market power to do so, you should direct that evidence supporting that claim be produced.

Fourth, we remain very concerned that no specific information has yet been provided concerning WellPoint's plans for open enrollment in the District. We believe such information should be included in any amended filing. And we would invite you to consider the specific questions we raised in our March 6th letter to you on those points; in particular, questions 26 and 28 through 31, attached to our letter.

Fifth, and similarly, we remain concerned about how the need to serve shareholders will affect premiums, administrative ratios, medical loss ratios, after the conversion and merger. No data have been provided on these issues, and we think they should be pointedly addressed in the amended filing. And in that regard, we would invite your attention to question 33, attached to our March 6th letter.

Sixth, because CareFirst has placed so much weight on the proposition that a foundation

will be created to address any harm to the community, we believe CareFirst should include in its amended filing any analysis it has done concerning the effectiveness of foundations in other jurisdictions to address those harms.

Seventh, as we said in our March 6th letter, we think it's very important that CareFirst demonstrate its compliance with all of the conditions in your December 1997 order--that is, the order of your predecessor--approving the merger of the Maryland and D.C. plans.

We recognize that your March 21 letter has focused on certain of those conditions, but we think all of them are important as a measurement of CareFirst's ability and willingness to meet any conditions you place on the proposed conversion and merger now before you.

That is why we think CareFirst should be required to show its compliance with all the conditions imposed in your order. But if that is not done, then there are two conditions in particular that we think should be addressed in

CareFirst's amended filing. And they've both been touched on tonight, but let me repeat them.

The first is the requirement in conditions one and nine of that order, requiring CareFirst to continue to abide by the explicit requirement in GHMSI's federal charter requiring it to function as "a charitable and benevolent institution." It is not at all clear to us that CareFirst has met that condition. And if it has, it should show how it has.

COMMISSIONER MIREL: "GHMSI" [pronounced "jimsie"] is G-H-M-S-I?

MR. SMITH: Yes. That's our short form. I'm saving time.

COMMISSIONER MIREL: I've never heard it called that before. Thank you.

MR. SMITH: Our March 6th information requests have probed this particular issue in questions 22 through 24, 37, 39, and 46. And there we specifically inquired about CareFirst's accumulation of substantial surpluses, and how those surpluses have furthered its charitable and

benevolent obligations.

In addition, in light of the considerable testimony over CareFirst's executive compensation package, we believe you should direct that CareFirst show its compliance with condition 12 of the 1997 order. That condition required, as you know, among other things, that change of control compensation be justified by an independent consultant confirming that that compensation is consistent with contracts "in similar non-profit settings."

Finally, we'd like to bring to your attention the need to put in place mechanisms for ensuring that the public, public interest groups such as D.C. Appleseed, and coalitions such as CareFirst Watch, will have access to the data they need to assess whether the proposal before you is in the public interest.

As you know, in our March 6th letter we list the data we thought we would need to fairly assess the proposal. And as you may know, we have met with counsel for WellPoint and CareFirst, and

we have emphasized to them the importance of our acquiring such data.

They have indicated an interest in working with us to provide the data. However, if they choose not to do so, we will then need to seek your assistance in acquiring that data. In our view, neither you nor we can ask independent experts to assess whether this proposal is in the public interest without obtaining the necessary data from CareFirst and WellPoint.

Their experts obviously had such data to do their studies. We now need such data to do our own studies. We believe CareFirst and WellPoint recognize this to be so. And since our studies must begin immediately, if they are to be ready for the hearings you have planned later this year, we hope to receive the necessary data shortly. And if we do not, we will be seeking your assistance in doing so.

Thank you for holding this hearing tonight, for planning the future hearings in which the public may participate, and for taking steps

that are necessary to ensure that the public interest is fully protected in these proceedings. I thank you.

COMMISSIONER MIREL: Thank you very much, Mr. Smith.

[Applause]

COMMISSIONER MIREL: Please. The next witness is Dr. Robert Cosby. Dr. Cosby?

STATEMENT OF ROBERT L. COSBY, PH.D.

EXECUTIVE DIRECTOR, NON PROFIT CLINIC CONSORTIUM

DR. COSBY: Commissioner Mirel, Ms. Johnson, Mr. Monroe, good evening. My name is Robert Cosby, and I am the Executive Director of the Non Profit Clinic Consortium here in Washington, D.C. "NPCC," as we refer to it, represents 14 agencies now, and 35 health clinic sites in the District of Columbia.

These non-profit neighborhood-based health clinics provide essential primary health care and what we call "wrap-around services" for almost 30 percent of the under-served and two-thirds of the uninsured here in the District of Columbia.

Typically, our NPCC patients are those that are uninsured, under-insured, immigrants, and the homeless.

NPCC opposes the sale of CareFirst-Blue Cross/Blue Shield to WellPoint Health Networks, and I will tell you why. Despite the logical and well-rehearsed presentations of leaders from CareFirst, I respectfully liken CareFirst's sale to an analogy of selling our collective souls for a pot of gruel.

It smells good; looks good on the surface; but underneath, there is not much there to sustain or nourish the community.

If the deal is really that good, why not increase the sale by four times, to reflect the true cost of care for the four jurisdictions that must provide care to those that may lose insurance?

If this sale moves forward, the loss for many may not be immediate. The checks for executives will have cleared at that point. There will be, in all fairness to WellPoint, other insurance products available to consumers--Sorry about the "products" comment.

Unfortunately, what is not said is that what won't be shared is the long-term high cost to the community, in terms of consumers that will be saddled with higher premiums, and the community that must bear the cost of providing care for those who are unable to be insured.

Put simply, the offer by WellPoint Networks is not a good deal for the District of Columbia. I believe that you will see that there is substance to my testimony in why I am saying that.

First, non-profit to for-profit status, as you've heard throughout this evening, and certainly in last Thursday's testimony--The sale from a non-profit to for-profit corporation will create less choice for eligible persons seeking health care and for those currently insured by CareFirst-Blue Cross/Blue Shield. I can say in my family we are CareFirst-Blue Cross/Blue Shield recipients.

Responsibility to the community is lost. So second, I believe there is a fundamental responsibility to the community to provide

affordable health care as a condition of its tax-exempt status. This obviously, I believe, will be lost, given the WellPoint goals and responsibilities to its shareholders. You've heard that as well.

The potential number of uninsured is to increase. NPCC represents primary health care clinics that provide this care to the under-served and uninsured. And we believe that the sale therein will create more uninsured, who will be seeking care at non-profit clinics like ours. Burdening an already fragile and over-taxed health care safety net and delivery system will further destabilize the system, so as to cost the District more money long-term, and make the District responsible for residents unable to afford insurance.

Just to give you an example of how difficult that can be, you only need look at the closure most recently of D.C. General and the creation of a health care system that's supposed to replace it. And I think the verdict is still out

as to our relative success there. We're working towards success, but I think that that verdict is still out.

In addition, the sale potentially creates problems for taxpayers, in that residents that were able to potentially pay taxes may be less likely to do so. And where CareFirst has an obligation to be a good neighbor, WellPoint is responsible to those in the State of California, not the District of Columbia or Maryland or Delaware or portions of northern Virginia.

And previous testimony by residents of northern Virginia bears witness to this phenomenon, citing the Trigon sale as the most recent example--or potential sale, I should say--of the corporate mergers at the expense of consumers.

Where NPCC recognizes that health care for the under-served does not hold much weight when compared to the lure of dollars, I can say that these dollars may provide short-term financial gain to the District and substantial profit for a few, at the expense of health care for hard-working

persons, including the poor and older persons.

Therefore, we oppose the sale of CareFirst as detrimental to the D.C. community. I don't disparage CareFirst leaders for wanting to push this deal through, or the enlightened self-interest of some executives to receive a big payday if they get the deal done. However, it would appear to me that North Carolina, South Carolina, Georgia, Missouri, Kansas, California, and now Virginia, to mention but a few, have some experience with these "conversion blues." While the songs may be sad, the bottom line is that costs to communities are greater.

"Conversion foundation" is a relatively new term of less than ten years. And it's been added to our lexicon and to communities like ours as they embrace the sale of non-profit corporations. The results have consistently pointed to long-term increases in costs to consumers.

By allowing this sale to move forward, we are approving of what I call the Adam Smith

"invisible hand" economic approach to the marketplace to decide the fate of too many people. To say we are sorry later on just isn't acceptable. Is this in the public interest?

Establishing a foundation with the current sale proceeds which could provide somewhere in the neighborhood of $400 million to the District is perhaps very good. But this one-time windfall, if used appropriately, could provide help for approximately five to seven years. In present value, when controlling for inflation, this $400 million really is a lot less.

So if we put this into a conversion foundation, that perhaps could help even more years--maybe, let's say, three, five, maybe even seven. But you've heard the numbers in terms of the costs for care.

Current research shows that foundations--Like the Schramm report points to how they can't afford to pay in the long term for direct services or ongoing care. So on behalf of the providers of care for the under-served and the uninsured, I can

say that this Adam Smith "invisible hand" is really like what I'll call "an iron fist in a velvet glove."

This conversion creates lots more problems than solutions for the under-served in the District of Columbia. It doesn't do much for older persons, either, or hard-working persons in need of affordable health insurance.

So I'm asking you to do the right thing: To look at these issues carefully, and to see the impact on the community.

The District's goal, I believe, is one to be able to work towards the creation of an integrated health care delivery system. And whereas I know that's not your responsibility, I believe that you have some responsibility in making certain that there are appropriate insurance vehicles to support that delivery system.

A healthy community includes persons that can afford adequate health care, with insurance options that are affordable. CareFirst has an obligation to the community. And we need your

leadership as a commissioner, and certainly your colleagues, to weigh in on the merits.

If you can weigh the merits of this, the District will need to build more continuity of care and to have providers and residents within the community that understand how care can be found and used. This should include insurance products that are affordable.

All of my research, and that of many others on the subject of conversions of this type, point to a history of more expensive insurance, with fewer options.

This conversion does not benefit the consumer, as we see it, or our clinics, or the District of Columbia. Please don't allow this fast-money opportunity--that benefits Wall Street, that benefits CareFirst executives--to sway your thinking. Our recommendation is to reject this conversion proposal.

Thank you for the opportunity to listen to what I've had to say, and I hope that you will give this serious consideration. Thank you.

COMMISSIONER MIREL: Thank you very much, Dr. Cosby. I appreciate your being here.

[Applause]

COMMISSIONER MIREL: Please. Please, please, please.

Patricia Thompson. Is Ms. Thompson here?

MS. VILLEDROUIN: She's not here, but I'm presenting for her.

COMMISSIONER MIREL: Okay. If you will identify yourself, please proceed.

STATEMENT OF MARY TITUS VILLEDROUIN

PROJECT DIRECTOR, ALLIANCE FOR FAIRNESS IN REFORMS TO MEDICAID [AFFIRM]

MS. VILLEDROUIN: Sure. Good evening, Commissioner Mirel, Ms. Johnson, and Mr. Monroe. Thank you for allowing me to testify on behalf of Pat Thompson. My name is Mary Titus Villedrouin, and I am the project director for the Alliance for Fairness in Reforms to Medicaid.

COMMISSIONER MIREL: Can I ask you to spell that, please, for the purpose of the record?

MS. VILLEDROUIN: Also known as "AFFIRM,"

A-F-F-I-R-M--"M" as in "Medicaid."

COMMISSIONER MIREL: No, it's your name we want you to spell.

MS. VILLEDROUIN: My name?

COMMISSIONER MIREL: Yes. So we will get it right on the record.

MS. VILLEDROUIN: V-I-L-L-E-D-R-O-U-I-N.

I'm going to be very brief, because I'm also extremely nervous and cold. So I'm just going to give you a brief summary--

COMMISSIONER MIREL: Sorry about the cold.

MS. VILLEDROUIN: --and ask that the whole statement be admitted for the public record.

COMMISSIONER MIREL: Certainly.

MS. VILLEDROUIN: AFFIRM is a non-profit, consumer-based advocacy organization that works with the District of Columbia residents, other community-based organizations, and local government agencies, to ensure that District of Columbia consumers are provided with fair, quality, and affordable health care.

The Alliance for Fairness in Reforms to

Medicaid opposes the conversion of CareFirst to for-profit status, for the following reasons:

There is no convincing evidence that's submitted by Blue Cross/Blue Shield that a conversion is in the public interest. Nor is there a reason thus far presented that it is essential for CareFirst to convert to maintain viability.

Number two, a conversion would more than likely increase premiums, especially for individual subscribers, persons with pre-existing conditions, and small employers; and would thereby increase the number of the uninsured and under-insured in the District of Columbia.

CareFirst should be constrained to follow its traditional mandate: the basis for which CareFirst was granted tax benefits over a long period of time. It was to serve the medical needs of the public, especially individuals who are unable to afford care. A for-profit health plan in the District is not mandated to have an open enrollment program.

According to the Accenture report provided

by CareFirst, as of November 2001 there were only 678 individuals insured under the open enrollment program for the District of Columbia Blue Cross/Blue Shield; and as such, the District of Columbia Blue Cross/Blue Shield did not comply or operate as the "insurer of last resort." In other states, such as Maryland, Blue Cross/Blue Shield has traditionally been the "insurer of last resort." With the change in status, there is no guarantee of an open enrollment program.

AFFIRM did not agree with the evidence provided by CareFirst and WellPoint, because these arguments have not proved to be in the best interests of the citizens of the District of Columbia.

In addition, AFFIRM is unable to identify the "true" valuation of the CareFirst holdings that would adversely affect the District and its residents. Thank you.

COMMISSIONER MIREL: Thank you very much. I appreciate that. We will look at your complete record, your complete testimony.

MS. VILLEDROUIN: Thank you.

COMMISSIONER MIREL: Okay. The next person on my list is Gregory New. Is Mr. New here? Okay.

MR. NEW: I appreciate the fact that you slipped me in.

COMMISSIONER MIREL: Well, we found that you had indeed e-mailed us, and we regret that you were left off the original list.

MR. NEW: Yes. I actually got a confirmation, I think dated May the 13th.

STATEMENT OF GREGORY NEW

PRESIDENT, D.C. FEDERATION OF CIVIC ASSOCIATIONS

MR. NEW: Good evening. I am Gregory New--that's N-E-W, as in "New York"--President of the D.C. Federation of Civic Associations, an organization of more than 40 neighborhood associations in the District of Columbia. I'm here to express the federation's opposition to the conversion of CareFirst-Blue Cross/Blue Shield to a for-profit corporation and sale to WellPoint, because it would be bad for our community.

We believe CareFirst should instead be required to return to implementing its original mission as a not-for-profit insurer of last resort.

We wish to make the following five points:

The original Blue Cross/Blue Shield was incorporated and received important tax concessions as a not-for-profit entity to provide community-based health insurance for all our citizens. The concessions were especially based on the obligation to take care of particularly vulnerable individuals who have no other access to health insurance; that is, they receive consideration because it was supposed to be the insurer of last resort.

In recent years, it has strayed from this mission, and has been acting as if it were a profit-seeking entity. Not only would CareFirst be required to remain a not-for-profit company; but also, it should be required to return to its mission as our not-for-profit insurer of last resort.

Blue Cross/Blue Shield and its predecessors, the separate Blue Cross/Blue Shield

plans for the National Capital Area, Maryland, and Delaware, have been sheltered from paying tens of millions of dollars in income and premium taxes, in exchange for providing insurance for individuals and groups that would otherwise be uninsurable.

In recent years, CareFirst has turned back on our most vulnerable citizens. It has unilaterally discontinued coverage for many individuals and small groups; closed down its HMO for Medicare patients; walked away from its HMO for Medicaid recipients.

At the same time, it implemented double-digit premium increases, and amassed 700 million in reserves. A large portion of these funds should have been spent on health care for which it received tax concessions.

Two, if CareFirst becomes publicly traded, dollars that should be spent on patient care will be diverted to stockholders. A recent study showed that as the independent non-profit Blues plans have consolidated and become profit-seeking, the proportion of premiums that go to patient care has

decreased an average of 10 percent. Where did the money go? To management, and to shareholders.

We respectfully submit that any further decline in the dollars spent on patient care in the District of Columbia will result in disaster.

Three, CareFirst maintains that if the deal is allowed to go forward, it would turn over its net worth--some $1.3 billion--to the three jurisdictions where it does business: Delaware, Maryland, and Washington, D.C. We have heard credible reports that this figure represents a serious under-estimation of the true value of this very healthy company. It is thus imperative that the Insurance Commissioner order an independent full audit and valuation at once, even before he begins his deliberation.

But even if the $1.3 billion were accurate, we suggest that a sound not-for-profit CareFirst that continued as the true insurer of last resort would better serve the District.

Four, decisions about the region's largest health care plan should be made in the region, and

not three time zones away. You can see that we don't believe the assurance of your first witness. We think that the profit motive would put the power in the hands of the conglomerate at the top, and not of the subsidiaries down below.

All health care decisions, like all politics, are local. Management of conglomerates is not notoriously local. Managers in Thousand Oaks, California are not likely to have the interests of the District citizens foremost in their minds; especially when their main concern will be for their bonuses and the dividends to stockholders.

Five, CareFirst claims that it needs WellPoint's investment capital to become more efficient and competitive, and to grow. This claim would be funny, if it were not so vexatious. CareFirst has more than 700 million in reserve, well in excess of the statutory requirements. It has just made massive capital improvements in its computer system. CareFirst already is the dominant insurer in this market. It simply does not need to

get any richer, or any bigger, or any better endowed, to serve our citizens appropriately.

In summary, we oppose the privatization of CareFirst-Blue Cross/Blue Shield, whether or not it sells itself to another company. We also oppose the sale of CareFirst to a geographically remote entity.

We hope you, the Insurance Commissioner, will order CareFirst to resume implementing its mission as the insurer of the last resort for the citizens of the District of Columbia.

And in closing, I'd like to thank you for scheduling these hearings in the evening, to allow people to attend. Thank you.

COMMISSIONER MIREL: Thank you very much, Mr. New.

The next witness is Al Silver. Is Mr. Silver here?

MR. SILVER: Yes, I am, sir.

COMMISSIONER MIREL: Yes. Okay. Welcome.

STATEMENT OF AL SILVER

MR. SILVER: Yes, sir. Mr. Chairman,

board, my name is Alan Silver, S-I-L-V-E-R. I live in Upper Marlboro, Maryland. And I've been a licensed insurance broker for over 25 years.

I feel one thing that gives me a little perspective that isn't bad is I took a sabbatical from the insurance business for 18 years; kept my license active; always knew I'd go back into one of the finest professions; came back last May. What gives me a certain perspective is, I truly see the forest, and I haven't been stuck in the trees.

This is an interesting situation that you have. I've been listening all evening. And one thing that I find very distressing is that testimony presented hereto has described the non-profit company called "CareFirst" having premium increases of two to 250 percent in the last few years. And I have no reason to doubt the validity of the previous testimony.

I constantly hear non-profit is better than profit, because profit works for shareholders. If this were the case, every ship being built in America would be built by the Department of the

Navy, and not private enterprise. There are school systems right now throughout this nation that are being run by profit over non-profit.

I would submit to everyone here, non-profit does not mean less expensive. Non-profit doesn't mean better service. It means there's an IRS form at the end of the year that's filled out called "non-profit."

When I listened to doctors that have been up here talking about medical costs--and WellPoint pays 75 percent, has been the figure bantered around; and CareFirst about 85--I don't know what that means, because I know 25 percent of the costs are drugs. I keep hearing doctors in hospitals. But a large company does bargain better with drug manufacturers.

This company, WellPoint, as many of you might know, is the first company that took on the drug people, and basically said that Allegra--and I can't remember offhand the other drug--should not be sold as prescription; that that's a terrible injustice. The FDA took up the challenge, and we

now have that those drugs are going over-the-counter. That was WellPoint did it, not a non-profit group; not a commission in any state.

It was a profit motive. WellPoint said it: "We will save $36 million a year," was the quote in the Washington Post. I have no reason to doubt that. Was that good for everyone? I believe so. Especially, I have some asthmatics in my household.

I think that the fallacy constantly I've heard is: profit means the shareholders. I would submit to you, the only way the shareholders are going to make a penny is if that company does a fine job. If they don't service the market and the people, they won't make a profit to shareholders. The company will be out of business. So to equate that profit is negative in this area called "health care," I don't think is real.

I could better find myself arguing that non-profit is worse in delivery, because of culture and attitude. But I don't have to argue that. That God, that's not my job.

But I can point out a simple thing. I've dealt with both companies since I came back into the business. I have over 40 cases in about eight months with CareFirst, small business--like Mr. Miller who talked earlier. I have a few with WellPoint's subsidiary, called "Unicare," in northern Virginia.

And I will tell you a few things. One, Unicare's price for small groups is less expensive than CareFirst's in the same area. Gee. How is this company working for shareholders in California able to sell comparable products for less, if I go by what I've heard tonight? That I can tell you is a fact, and I'm going to leave a copy.

Now, it's not oranges-to-oranges, apples-apples, because they don't sell the same products. I would tell you that the Unicare one is a PPO, and the CareFirst is an HMO. That makes that CareFirst should have been less expensive, in what is good pricing. So though there are some differences, it's pretty accurate.

I can also tell you, dealing with Unicare--And let

me preface this. CareFirst has some excellent people. It is not my position to stand here and denounce them. I've heard a lot of that. I am fascinated by telling us all that's wrong, "But we don't want them sold." What do you want?

I can tell you that CareFirst does certain things--

[Statement From Audience Member--Inaudible.]

MR. SILVER: Ah, no, I was up in Canada for a long time. No, thank you.

CareFirst does a lot of things correctly. But so does Unicare. But Unicare seems to be more responsive to the clients. They've been voted three years in a row, WellPoint, as the best managed care company in health by "Forbes" magazine.

I can tell you that whenever I call, I get a response. I cannot say that's the same with CareFirst. Do I think that's profit versus non-profit? I won't make that step. But I do know that you get the phones answered. And if you want

to provide care, that is so critical to everyone involved.

I can also tell you that it is my understanding in northern Virginia INOVA has been given the contract to handle Medicaid and Medicare in the northern Virginia area, and they turned to WellPoint's company, called "NCPPO," to be the administrator. They didn't turn to CareFirst, who sells in northern Virginia. They didn't turn to Aetna. They asked NCPPO, who's owned 80 percent by WellPoint, to administer. Now, that tells me that the hospitals and doctors of northern Virginia respect that company, in terms of its ability to handle claims and pay.

So again, I'm not a professional on this. I'm only here to say that, one, I don't think it's legitimate to say profit means the stockholder first. I believe profit means the clients first, so the stockholders can make their rightful return.

I also believe that when you look at drugs--which take up a good 20 to 25 percent of costs of health delivery--larger, unfortunately, is

better. They do get things cheaper. The same product we know sells for less by buying by large bulk.

And they are a very aggressive company in dealing with this. So therefore, maybe their increases in medical outlay is [sic] for efficiency, knowledge, and ability. I don't know. But I do know, where they do compete, they are less expensive. And I would tell you, it's the same thing with their personal policies.

I thank you for allowing me the time to speak. I leave this little--which I will gladly inform anyone where they draw it off.

COMMISSIONER MIREL: Thank you, Mr. Silver. Thank you for coming down from Upper Marlboro.

Urla Barrow? Is Ms. Barrow here?

MS. BARROW: Yes.

COMMISSIONER MIREL: Yes.

STATEMENT OF URLA BARROW

COMMUNITY MEDICAL CARE

MS. BARROW: Thank you, and good evening. My name is Urla Barrow, and I am the Executive Director of Community Medical Care. We are a small, faith-based health center that has served low-income residents of Washington, D.C., for the past 24 years.

My health center opposes the proposed conversion of CareFirst-Blue Cross/Blue Shield to a non-profit [sic] status, and a subsequent acquisition or merger with WellPoint Health Networks of California, because this is ultimately not in the best interests of the patients that we serve.

My objection is based on the fact that I remain unconvinced that there is anything in this proposal that promotes the public interest. This is a conversion that benefits only WellPoint shareholders and CareFirst executives.

Community Medical Care believes that, due to the control that WellPoint will exercise over

CareFirst, it is highly probable that the conversion would likewise have a negative effect, in that CareFirst will not maintain its original charitable mission and public service values.

If this merger is allowed to take place, I see a future for my health center with an increased number of uninsured and under-insured to serve, since they will not be able to afford increased premiums--and premiums will increase; if not immediately, eventually. This will drain the already very limited resources of my health center.

I see residents with prior existing conditions, chronic illnesses, and individual policy holders being shuffled around; having to deal with levels of denial issues, disputed claims, and generally suffering under this system because of loss of coverage.

Studies of conversions around the country conducted by a number of health industry analysts and other independents have concluded that conversions in other states have not had a positive impact for the public or for providers.

My health center questions the motives of CareFirst senior executives. These questions need to be subject to intensive examination and analysis by the Office of the Commissioner, the Corporation Counsel, and the District elected officials.

The community has received no explanation for the 1.3 million sale price negotiated by CareFirst and WellPoint. When Virginia's Trigon announced the agreement to the acquisition by Anthem at a higher price than CareFirst, while serving fewer subscribers, CareFirst-WellPoint offered the public no satisfactory response. We believe there are a number of gray areas which need to be explained, in the interest of credibility, regarding this transaction.

Community Medical Care is in the process of moving its health center to Ward Five from Ward Two, after 24 years of service. This is a community that easily qualifies as a health professional shortage area and a medically under-served area. The health indices are appalling for the uninsured and the under-insured, and for all

low-income families. This ward ranks highest in the death of HIV/AIDS and in infant mortality.

It is recorded that over 18,000 people in the U.S. die from preventable diseases because they lack insurance; but conversions are now being accompanied by increases in premium costs. It is critical to the health centers that form the safety net, such as Community Medical Care--and I'm one of the health centers that make up the Non Profit Clinic Consortium that Dr. Cosby heads up. It's critical for all low-income patients to be heard.

We are the ones that survive on shoestring budgets, while serving everyone who walks through our doors. We are the ones who take less than competitive salaries, and work twice as hard to keep our doors open. We ask you to take the kind of decision that would complement our efforts to provide affordable, high-quality, accessible health care services and fairness for all the health care consumers. Thank you.

COMMISSIONER MIREL: Thank you very much, Ms. Barrow. I appreciate your coming down.

And I appreciate, all of those of you who are still here, for staying. I know it's getting late, but we'll move right along. I think we're on schedule.

Peter Espenschied? I'm sorry, did I mispronounce it?

MR. ESPENSCHIED: Espenschied.

STATEMENT OF PETER ESPENSCHIED

MR. ESPENSCHIED: My name is Peter Espenschied. I am a founding member of the Community Council for the Homeless at Friendship Place, and a member of its board of directors. I am co-chairman of the consumer affairs committee of Advisory Neighborhood Commission 3C--Cleveland Park, Woodley Park, McLean Gardens. And I'm also vice president of the Cleveland Park Citizens Association. None of these entities has taken a position on this matter, so I am testifying today only as an individual.

The D.C. Commissioner of Insurance must decide whether it is in the public interest to allow CareFirst to convert to a for-profit

corporation and be acquired by WellPoint Health Networks, Incorporated, of California.

It is a sad state of affairs when a proposal like this one must be treated as a serious public issue, as though there were real advantages and disadvantages on each side to be carefully weighed and considered. This is not an issue. What the Insurance Commissioner has before him is a thinly-veiled effort to license a private feeding frenzy at the public trough.

This is a proposal that can well be judged by the company it keeps. There is no independent responsible body of opinion that favors it. Views ranging from skepticism to condemnation are held by dozens of well-credentialed groups who see it for what it is: a plan to raid the till of a large non-profit organization that performs a vital public function.

The efforts to pressure the state and District commissioners have focused on the claim that if CareFirst is sold now, it will get top dollar; whereas, if not sold now, so-called

"industry consolidation" will somehow force CareFirst to later convert and be sold at a cheaper price. The Commissioner needs to closely question how industry consolidation will force CareFirst to do anything, and analyze the quantitative model, if there is one, on which this claim is based.

The embarrassing rationales that have been offered by the promoters of this scheme in order to identify it with the public good show us how ambitious dreams can compromise the intellectual faculties of otherwise reasonable men. Can anyone take seriously the proposition that by taking a layer of profit out of the company's premium income, one will improve the benefits available to policy holders, or improve the financial stability of the insurer?

For an insurance company, the conversion to for-profit means adding a whole new class of beneficiaries--that is, the new stockholders--who must be paid out of the existing premium income. Of course, that generates an immediate pressure to raise the premiums. The Insurance Commissioner

then hears that he must allow the premiums to be raised so that stockholders can get a "fair return on their investment."

This is a purified archetype of corporate welfare: the poor subsidizing the rich.

If CareFirst becomes WellPoint, then two things happen, inevitably:

One, the policy holders who are allowed to remain will pay higher premiums, or receive lesser benefits, or both;

Two, the government will receive a pot of money with which it will have to find the means to become, in one way or another, the new insurer of last resort for all those dropped, now or later, by WellPoint, and for whom there is no place else to go. When that money runs out, what happens to them?

Does any good come out of all that? Only for the insiders, who would profit from it. Would there be a harm to the public? Clearly, yes. Can this deal be honestly characterized as being in the public interest? Clearly, no.

A nice perspective on the conversion was offered in January by Delegate Michael Busch of Annapolis. He said, "This smells like bad fish. We're talking about having our insurer of last resort sold off to a company that's three time zones away. Tell me, how can that be good for Maryland?" We should ask: How can that be good for D.C.?

In February, the Kansas insurance commissioner disapproved the proposed acquisition of Blue Cross and Blue Shield of Kansas by a for-profit company, as not in the public interest. We're not in Kansas, but we can profit from her example. Thank you.

COMMISSIONER MIREL: Thank you very much.

The last person on the list is Bob Peck. I will then go back and see if some of the ones who were not here before would like to testify, and then, if we have some time, anyone else who is here who wants to testify. Bob Peck?

[No Response]

COMMISSIONER MIREL: Well, then, let me go

back and see if Mr. Durant is here. Guy Durant?

MR. DURANT: My name is Guy Durant. I didn't create any written statement, but I have a written outline. I could give it to you.

COMMISSIONER MIREL: That would be fine; or if you want to use the outline and create one after the fact and get it to us. Either way is fine.

MR. DURANT: Okay.

STATEMENT OF GUY DURANT

MR. DURANT: I'm glad that I came. First of all, thank you, Mr. Chairman and panel members, for allowing me to speak. I apologize for being late. But I have enjoyed everything I've heard. There's been so many good speakers, I'm not sure I could add much content. I guess what I'm adding is the philosophy at this point.

I'm very grateful that I was able to come after Mr. Silver. And I'll try to only use five minutes, if possible. Basically, I want to answer Mr. Silver directly. And the way I want to do that, he talked about how he didn't think the

profit model was going to be a problem. And actually, he thought the profit model and being a for-profit corporation might actually help the situation.

And to that, I'd like to answer directly: Rent the video "Wall Street." We've heard that argument before. In the movie "Wall Street," you'll see Michael Douglas say, "Greed is good." Very persuasive. He does a great job. If you've never seen that movie, I'd advise you to rent it. He sits up in a board meeting, where everybody is weighing something very important about a merger, or some kind of takeover--I think it was a hostile takeover in that movie. And he makes the argument that "Greed is good."

And I won't repeat it all here, because the emotional impact of it is very well done in that movie. And that's basically what Mr. Silver was saying. He was saying greed is good. I'm here to say that greed is evil. I'm here to say that death is evil. Higher costs are going to create greater death. CareFirst and WellPoint are going

to create higher costs. The devil is in the details. CareFirst and WellPoint are going to come together, and that'll make this merger from the devil.

The non-profit soul is being sold for 1.3 billion. The merger support only comes from soulless profiteers and sold-out politicians. So, who do you work for?

And then, I would like to make a few other points. Basically, the reason I came into this was because I'm a computer consultant, a small business person. I recently went shopping for health care. I was part of a group plan before, but when I started my own company, I had to look for an individual plan until I started to grow.

I got a Blue Cross CareFirst individual plan. And one of the things I noticed was, yes, there are problems with the efficiency of CareFirst. When I went shopping for this policy, the website was not as user-friendly as it should be. There were problems sending in applications; there were problems getting people on the phone;

all those problems Mr. Silver talked about that a profit corporation might be able to address, efficiencies and things of scale.

But I think that's part of the evil plan. And let me just tell you why. Because I wrote an e-mail to Mr. Jews. He did not exactly respond. But I pointed out and I suggested to them, as a business person, you know, "You guys are doing good as far as with the plans you have. But as far as your business efficiency, you are a little bloated, and what is going on with this?" Didn't give me a response, but I can tell you what my theory is. This is just my theory.

My theory is, they're doing this on purpose. And I'll tell you why. They want to fail. That sounds ridiculous but, remember, this is evil we're talking about, and this is where the devil comes into this. Because they're going to come back to you, and they're going to say, "Well, we can't be efficient, and we can't do things being a non-profit." So they're going to force themselves into failure, so that you guys will then

later on have to let them merge with someone else. So watch out for that. That's coming.

That's what they've been crying all this time, is they have to merge in order to be efficient. I'll give you one good example. The good example is, I said, "Can I pay my premiums with a credit card?" No. CareFirst won't take credit cards.

Has anybody who's got CareFirst been able to pay with a credit card?

They won't take it. Now, what kind of company won't take premiums with credit cards? They have the technology. They've got the website. They're able to do it. But they won't.

Not only on that--Now, that may just be an oversight. Maybe they haven't gotten around, in the year 2001, to accepting credit cards. But on top of that, when I said, "Well, okay, I'll mail in my check. Where do I mail it to?", you mail it to Baltimore. So I mailed my check in to Baltimore. But it's processed in the D.C. office. Southwest.

So I call up; finally get somebody on the

phone. I say, "Okay, what happens when it goes to Baltimore?" It goes to a lock-box in Baltimore, until they ship it down by courier to the southwest office. So what is going on there? That's a management problem. That's coming from Mr. Jews and his staff.

So as a business person, I'm looking at this, I'm saying: They've got to be doing this on purpose. They're not getting all this money to be idiots. They don't accept credit cards, so their cash flow is obviously hurt, because that's one way that people can make payments. They're sending payments off to another area, where they don't process it.

And the lady on the phone said, "Look, send it to me. I'll give you the address here in southwest. And it'll be processed faster." Because they obviously know that they'll be processed if you send it there directly. They don't want you to; that's not the address they give you to send the bill to. But when you send it to them in southwest, it does get processed faster.

Now, that's a plan for failure. They want to fail. And the only way to correct that--And Mr. Silver asked, "What do you want done? And if it's so bad, why do you want it to be a non-profit?"

It's a management problem. We have to get rid of the management. We have to get rid of the devils at the top.

And since they're working for the devil and they're evil, the only way to really get rid of them is to deny this merger. Because that will show to their board and to anyone else in the CareFirst system that they weren't able to achieve the satanic goal of merging.

So once that happens, once the merger fails, those guys are gone. They're gone. They're exorcised. The evil is gone, because it's the management's fault: It's management that's not allowing credit cards. It's management that is not allowing the efficiencies. It's management that's sending the bills to Baltimore, and not letting them be processed in southwest.

WellPoint's not going to solve that

problem. Or, they will--sure they will--but at a price. That price is too high.

So the kind of efficiencies that we want, the kind of progress and things that need to be done, can be done right now, if the devils at the top would just stop worrying about getting money in their pocket, and start worrying about how they can serve the public better.

I mean, these are guys that are business professionals. I'm not here to tell them how to do their job. I'm just telling you, if there's any problems with the way CareFirst is being run, it's coming from the top, down. People at the ground level that are running the policies, the underwriters, those guys are great.

Now, as far as filling out applications, I can fill out an application--it's interesting enough--for a Maryland policy online. But when I wanted to fill out an application for my D.C. policy, I couldn't do that online. I had to actually mail it in. They wouldn't give me the address. And they had to send me a separate

photocopied form. And I said, "Well, why is that?" "Well, because, you know, the Maryland office is a little more efficient than the D.C. office." So they're setting you up. They're setting you up, because they've got this bureaucracy, and that's a bureaucracy that Mr. Jews and his crew have set up to fail.

So I just wanted you to be aware of that because, as a business person, I can just see that it's going to come down where you're going to come in here and they're going to say, you know, "Greed is good. We need profit."

Thank you.

COMMISSIONER MIREL: Thank you, Mr. Durant.

Let's see, we missed one other person. Winifred Williams. Is Ms. Williams here now?

[No Response]

COMMISSIONER MIREL: If not--and Bob Peck is not here--then we have a few more minutes. I will open it to anyone else who might want to testify.

Senator Strauss, you would like to testify for a few minutes? Okay. Welcome.

STATEMENT OF PAUL STRAUSS

D.C. SHADOW SENATOR, UNITED STATES SENATE

SENATOR STRAUSS: Thank you, Commissioner. I'll try and be brief. I know that there are some other folks that want to testify.

First of all, let me say I appreciate your holding this public forum. I have read your administrative order. I understand that the application is not complete, and this is not a formal public hearing. But I think you're doing the right thing by not waiting to give the public an opportunity to comment.

COMMISSIONER MIREL: Excuse me one second, Senator Strauss. Would you identify yourself for the record?

SENATOR STRAUSS: Certainly. I am Paul Strauss. I am the elected United States Senator, sometimes known as the "shadow senator." I appear tonight on behalf of my constituents but, perhaps more importantly, as a policy holder of CareFirst.

That is the company that insures me. It insures my family. And I am watching what's going on with great interest.

This is a preliminary forum, and the application is not complete. But preliminarily, I have a lot of concerns about this conversion. Now, my doctor has told me three things I've got to do this year, one of which is try and lose some weight; the other is to exercise some more; and the third is to oppose this conversion.

[Laughter]

SENATOR STRAUSS: And I don't want anybody to think that, because I seem to not be doing the best job on the first two, that I don't take my doctor's advice seriously.

The D.C. Medical Society has provided a very succinct statement, and their four factors give me cause for tremendous concern. Everyone I know in Maryland that studied this issue is opposed to what they've proposed there. And I think it's important, and one of the things that you stressed in your order that seems to make sense. And I know

you're a long advocate of D.C. and Maryland working closely together on a lot of issues, and this is certainly one where the two jurisdictions need to be unified.

And the fact that Maryland is not moving quickly to approve this means that we can keep our market, perhaps, together, and some of the dire predictions we've heard about what might happen if this conversion is not allowed to go through may not come to pass. Because we are a large market, and we are a profitable market, and they do have dominance in this market.

I heard what Mr. Durant, an old friend of mine, said about greed and so forth. And I've had an opportunity to speak to some of the people from CareFirst here tonight. I did notice the horn and pitch forks were conspicuously absent.

[Laughter]

SENATOR STRAUSS: That being said, I don't necessarily think that we need to view this simply as a populist issue against business. Yes, there is a populist interest at stake. The average

citizen needs to be able to buy affordable health care. Health care is important. But I'm also a small business owner. And as I look towards being able to provide cost for my employees, I'm concerned about the profits of my business, as well, if my insurance costs become too high.

So I think that there are a lot of businesses, as well as a lot of individuals, that are going to have concerns about this. And what might be good for this one for-profit business might end up being very, very bad for a whole bunch of other for-profit businesses that we have here in the District of Columbia, and for employers that want to do the right thing for their workers and provide quality affordable health insurance.

So because this is a preliminary hearing, I want to emphasize that my opposition at this point and concerns are preliminary. I think you've done the right thing by directing CareFirst to answer more questions and provide more information. And I look forward to watching this issue closely.

From what I have seen so far, I have a lot

of concerns. And that's been reinforced by a lot of excellent statements and some very, very good points. And I thank you, Commissioner.

COMMISSIONER MIREL: Thank you, Senator Strauss.

I see Walter Hill. Did you want to testify? Okay. Please identify yourself for the record.

MR. HILL: First, may I give you a copy of this?

COMMISSIONER MIREL: Please.

STATEMENT OF WALTER HILL
EXECUTIVE DIRECTOR,
WASHINGTON PSYCHIATRIC SOCIETY

MR. HILL: Mr. Mirel, I am Walter Hill. I am the Executive Director of the Washington Psychiatric Society. We are the professional organization that represents nearly 1,000 psychiatric physicians in the Metropolitan Washington area.

I appear before you tonight to speak against the sale of CareFirst to WellPoint Health

Networks, and thus the conversion of an organization that since its inception has served the people of Washington, D.C., as a non-profit corporation and as a keeper of the public trust. It will now become a private, for-profit entity.

WPS believes strongly that CareFirst's return on its investment should benefit the D.C. residents and businesses that built the organization, not shareholders of a private corporation. Our concern is that money that is now used to provide medical and hospital care for District residents will now go to pay dividends to shareholders, many of whom will live far away from the District and therefore have no concern for the public good of the residents and citizens of the District of Columbia.

CareFirst executives have been stewards of a community-owned asset. Now they stand to make millions of dollars through this proposed sale.

As physicians who often care for very ill patients in both in-patient and out-patient settings, the Washington Psychiatric Society's

psychiatric physician members can see no advantage to those patients should this sale go through.

Indeed, with the loss of community control inherent in the sale to WellPoint, the potential decrease in access to, and the availability of, psychiatric and other medical care seems likely to decline.

CareFirst is often the insurer of last resort for many people in the District. It will now focus on increasing its profitability, and turn its focus away from providing care to some of the District's poorest and sickest residents.

Already, in Maryland CareFirst has ended its participation in Health Choice, which is the Maryland Medicaid managed care program. In May of 2001, CareFirst announced that it was withdrawing its subsidiary HMOs from the individual and small group insurance markets in Maryland, because they were unprofitable. The company at that time, in 2001, predicted that over 6,000 people who had purchased medically-underwritten individual health insurance would not now satisfy the company's more

stringent requirements.

Given that these changes took place while CareFirst was a non-profit, we can only conclude that, as in Maryland, once bottom-line considerations are in place, the number of District residents deemed medically uninsurable will rise exponentially.

As people are dumped from the roll of the insured, who will cover the cost of their health care? Either people will risk their life savings to pay for a medical catastrophe, or the District of Columbia itself will have to pay for their care.

CareFirst was organized as a public trust. They disavow that promise to the District if they complete this business transaction. CareFirst cites the need to strengthen its financial house as the reason for becoming a part of WellPoint. And yet, the company's 2000 annual report states that CareFirst reserves rose by nearly $100 million, from 1999 to 2000. Their reserves are now $692 million for the last fiscal year for which there is reporting. And certainly, the $1.3 billion

purchase price offered by WellPoint demonstrates clearly the value of CareFirst's assets and its financial soundness in its present iteration.

Does CareFirst really need to get bigger? Does it really need to give control to a profit-seeking absentee shareholder, far removed from life in the Nation's Capital, so that this company can compete and survive? We at WPS believe that the numbers say: No.

We believe, further, that CareFirst's continuing commitment must focus on providing quality medical care to its enrollees; not on creating value for its shareholders.

As psychiatrists, WPS members are especially concerned about the plight of psychiatric patients, should this sale be completed. For years, the psychiatrically ill have been the victims of discrimination by insurers. Psychiatric treatment consistently and regularly undergoes a far more rigorous review by insurers and their behavioral health carve-outs than does treatment for any other diagnosis. Since the

advent of managed care, psychiatrists have seen a lessening of concern for psychiatrically ill patients.

While the cash assets of CareFirst have grown, expenditures for mental health care have dropped. Treatment plans are routinely denied. In-patient and partial hospitalization--day treatment programs--are reviewed at least every other day in some cases; all in an attempt by CareFirst's behavioral managed care carve-outs--currently Value Options, and soon to be Magellan--to increase the company's bottom line.

Often, persons who are in day treatment programs don't know until five o'clock in the afternoon whether or not their insurer will allow them to come back the next day for continued treatment.

In a straight for-profit situation, this deplorable occurrence can only get worse. Historically and consistently, the for-profit Blues have provided a much smaller share of each premium dollar to medical care than have the non-profit

Blues. Already, as much as 40 percent of the mental health care premium paid by consumers goes to administrative costs and for profit. It should go to direct care for the patients.

Mr. Mirel, your counterpart in Maryland, Mr. Larson, asked the Georgia representative of the Blue Cross program there--which has been bought out by WellPoint--he asked directly, "What is the loss ratio that you're experiencing since you've been for-profit?" The loss ratio being the amount of money that goes to direct care, as opposed to the amount that goes to administration and profit. He either could not, or would not, answer the question.

Sir, I ask you--I implore you--ask that question of WellPoint: How much of their income from the insurance premiums paid will go to direct care, and how much will go to profit, to administration, and to the shareholders?

The Washington Psychiatric Society urges you not to approve this sale. CareFirst is a public trust. A conversion to the for-profit

status will not perpetuate the availability of affordable health care coverage that has been the hallmark of the District of Columbia's ongoing care and compassion for the men, the women, the children, who are its residents and who work within this city.

Thank you very much.

COMMISSIONER MIREL: Thank you, Mr. Hill.

Anybody else who would like to testify? We still have five minutes.

[No Response]

COMMISSIONER MIREL: You don't have to. There's nothing wrong with getting out of here five minutes early.

I do want to thank you all for coming tonight. I learned a lot. We will take to heart everything you've said. And even the things that you submitted in writing that we have not heard directly, we will look at.

And please watch us closely. We're going to put everything that we do up on the website, and make it available. And I hope you will continue to

participate in the process.

Thank you very much, and good night.

[Whereupon, at 8:52 p.m., the proceeding was adjourned.]